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Visiting Nursing in Community Health Work

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EDITORIAL

RESIGNATION OF MISS WATERS

MISS Yssabella G. Waters, after ten years of voluntary service as director of the statistical work of the National Organization for Public Health Nursing, has resigned. The following resolution expresses inadequately the feelings and thoughts of the Board of Directors—and I am sure of the membership also—regarding her valuable service and the loss suffered by the Organization in her withdrawal.

WHEREAS, Yssabella G. Waters greeted this Organization immediately upon its inception in 1912 by offering her personal service and all attendant expenses and her accumulated work of 9 years prior thereto; and

WHEREAS, for ten years she has made this ever increasing contribution which at its maximum represented a staff of five assistants; and

WHEREAS, throughout this period of time, her records have constituted the only reliable and even approximately complete descriptive registration of public health nurses and public health nursing service in the United States; and

WHEREAS, the last two years of her service have constituted a peculiar expression of devotion in that they were given after she had tendered her resignation, in order to prevent the lapse of this work during the period of the Organization's financial stress;

THEREFORE, be it resolved that:

The Board of Directors in behalf of the entire membership of the Organization does hereby express to Miss Waters its profound gratitude for her great gift and fundamentally important work, its lasting appreciation of the personality which has made her presence on the executive staff a constant benediction and its deep sense of loss in her retirement.

A QUESTION OF INTELLIGENCE

IN THIS issue we publish some striking reports resulting from efforts to save infant life in this country. One of these reports—that of the American Child Hygiene Association—gives comparative rates of infant mortality covering 573 cities and towns in all parts of the United States, and shows in unmistakable language the beneficial effects of the good work that has been done by associations and individuals.

An unusual study by the Babies' Hospital of Philadelphia is interesting as showing the decrease in the number of acutely ill babies referred to the Hospital during the summer months, apparently due in considerable part to increased preventive work through the dispensary.

Yet a third report comes from the Baby Hygiene Association of Boston. In it we find a startling comparison

between the infant mortality rate for the 9722 infants under one year cared for by the Association, and that for the city as a whole—12.54 deaths per 1000, as compared with 77.8 per 1000.* A most remarkable achievement, surely, and one which bears eloquent testimony to what can be accomplished by the intelligent application of scientific knowledge.

Side by side with this comparison, however, we find reported the fact that, on account of financial pressure, it was necessary to reduce the Association's staff of nurses last fall; and this reduction was mirrored in the higher death rate of children between one and two years—a rate of 14.3 per 1000—this increase being due to the impossibility of maintaining a staff large enough to give to these little ones the attention they so evidently need.

If scales could be set before us and we could see on the one side of the balance the lives of little children, and on the other side so many dollars, could there be any doubt as to which side would be made to weigh the heavier? Can we believe that the words "economy" or "financial stress" would be permitted to count against the lives of the little ones? But unfortunately many of us are so dull of imagination that in such a report as this we see only another set of statistics; and the pressure of financial need, more personal and physical in its appeal, so falsifies the balance of our judgment that we allow the well-tried and splendidly proven efforts of those who are actually saving to the nation the builders and workers upon whom its future existence and prosperity depend, to be crippled and stultified for lack of the machinery necessary to the fullest success of their efforts.

A bank in one of our large cities recently placed in its window a poster bearing the following heading in big, black type that caught the eye of all who passed by: THE INTELLIGENCE OF THE AMERICAN PEOPLE. Beneath this heading the findings of the intelligence tests applied by the United States Government to men entering the army during the World War were charted; and then came this cogent sentence: "Intelligence is valuable in proportion to the use made of it."

An excellent text to set one thinking, and one which suggests lessons that are as applicable to the saving of infant lives as to the saving of money. For the preservation of these lives is not a matter of sentiment, but a question of intelligence—the intelligence not of individuals or of associations, but of the American people.

THE PASSING OF DR. STEPHEN SMITH

We regret to announce the death of Dr. Stephen Smith, first president and one of the founders of the American Public Health Association. Dr. Smith would have been one hundred years old in February next year, and his approaching one-hundredth birthday was celebrated in connection with the fiftieth anniversary of the Association, which occurred in November, 1921.

Dr. Smith originated the efforts which largely transformed the insanitary conditions of New York half a century ago, and was the first administrator of that city's Board of Health. To the end of his life he was active in public health affairs, for he believed in the health value of work. His physical presence will be greatly missed at the forthcoming meeting of the Association which he so largely helped to bring into existence; but the spirit of his work and influence will still be present.

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* While it is noted that this comparison cannot be exact, because few of the Association's babies are newly born, when the average mortality is greatest; it is also pointed out that the babies under the Association's care comprise about one-third of all the babies in the city and their low mortality rate exerts a decided and important lowering effect on the rate for the city at large.

THE PLACE AND VALUE OF VISITING NURSING IN COMMUNITY HEALTH WORK*

By KATHARINE TUCKER

Superintendent of the Visiting Nurse Society of Philadelphia

IN considering the place and value of visiting nursing in community health work, I would like to present general trends and tendencies, evidences of which are found pretty generally in all visiting nursing work today. A complete picture, including all of these possibilities, is probably not found anywhere as yet but each phase to be considered is somewhere actually in operation. Many visiting nurse associations, however, have incorporated the larger part of this outline in their programs. The following analysis can be most helpful to all of us if it merely serves as a basis for further discussion.

In order to understand our present situation better, let us first look back along the way which visiting nursing has traveled to see what have been the factors influencing its progress until we get the picture of visiting nursing work as it is today and may be tomorrow. This is a picture familiar to all of us. I just wish to note the outstanding features and certain changes of emphases.

Visiting nursing had its inception in the work of religious orders. Associated with their ministrations to the poor and needy was care of the sick in their own homes. In the centuries that followed, this work became dissociated from a distinctly religious service but remained primarily a charitable work for the sick poor. It was a humanitarian curative service to those who were too poor to procure it for themselves. This emphasis on the charitable, humanitarian, curative character of the work largely remained until visiting nursing associations were organized in the United States. The stated purpose of the Visiting Nurse Society of Philadelphia when organized in 1886 is one of the first illustrations of a change in emphasis: "To give to the poor and those of moderate means the best home nursing possible under existing conditions." A small fee was charged those who could afford to pay. This same conscious effort to make visiting nursing more than a service to the poor was evidenced in the organization of the nursing service of the Henry Street Settlement in 1893, as described in the "House on Henry Street." It has now become one of the fundamental principles of visiting nursing work in this country that its greatest value is not as a charity. Later the extended influence of this idea as found in our present work will be enlarged upon.

The next profound change in our conception of the place of the visiting nurse was brought in by the modern public health movement in which prevention is the key-note. Here we find the idea constantly reiterated that it is not enough to get people well but they must be kept from getting sick. In order to make this principle a fact, actually affecting the way in which people live, the nurse in the home was essential, not primarily in this instance for curative purposes but to teach the means of prevention. There grew up then a rather sharp distinction between the bed-side nurse and various types of preventive nurses. This emphasis, however, on the importance of keeping people from getting sick, had a tremendous influence on visiting nursing and we are now trying to make up for the opportunities lost on the preventive side.

Both out of this preventive movement, especially from work with the tubercular, and from social case work, came the emphasis on the importance

* Delivered at the Biennial Convention in Seattle, June, 1922.

of the family as a unit. It was clear that it was impossible to treat the individual fully, constructively and preventively, without taking into consideration social and mental as well as physical factors which might affect the situation. This broader comprehension of all that is involved has increasingly meant that our objective is *family health work*, no longer attempting to work with individuals as isolated beings. But one step further was needed. The family itself cannot be regarded as a separate entity as it in turn is affected by and affects the community. Therefore health work must be a community responsibility and concern. Throughout the recent developments in all sound social and health work it is generally conceded that it must be built on the foundation of community organization and participation.

And the most recent—one cannot say last in terms of final—development, which reveals the infinite possibilities ahead, is this movement for health education, health promotion, and for a *positive* health program. The significance of this development which is giving us all a new vision and a new goal for our work, has been dwelt upon so often throughout the convention that it needs no enlargement from me.

These various landmarks just touched upon have had the most profound effect upon visiting nursing. It has become a composite picture, incorporating into a whole with its earlier purpose the methods and techniques recently learned from new discoveries. This earlier purpose, the care of the sick in their own homes, is no longer an end in itself but rather the means to the larger end—family and community health work.

In analyzing in further detail this composite picture of our present day visiting nursing work, what do we see? First, that the non-charity concept has been adopted as a fundamental principle. In fact, it has gone so far that now it is the actual cost per visit that serves as the basis for the fee. Also many organizations include an hourly nursing service for those who do not need the full time of a private nurse but wish skilled care once or twice a day, and are entirely prepared to pay for this on an hourly basis. In mild or chronic cases or when the patient is convalescing, the hourly nurse is especially in demand. A higher price is charged for this latter service as it is more expensive to administer. The attempt is made to send a nurse at a stated hour because in more complicated households this is almost a necessity. Otherwise the service is offered on the same basis as the regular service. This means that the community is given a visiting nursing service democratically administered for the rich and poor alike. Those who can, pay in terms of the actual cost, but the same service is given to all. The advantage of including such an hourly service to those who in the past might have employed the full time of a private nurse, though only using or needing but a few hours of skilled nursing care, is that it is a real economy in the time of a trained nurse, as well as a financial economy, not to pay for more than is needed. Furthermore, it is well to remember that often the rich need a public health nurse as much as the poor, for tuberculosis, typhoid, malnutrition and many other preventable diseases are no respecters of incomes. In communities where hourly nursing is part of the work of the visiting nurse, a separate staff is not employed but each nurse within her own district takes both hourly cases and others. In the city that I know best this has worked most successfully with no difficulties arising from such a democratic service; in fact in one instance a grateful hourly patient gave the Society a Ford Sedan car as the distances were so great in the district of the nurse who attended her.

Of equal, if not greater importance than this curative side of the work has come to be the inclusion of a preventive and positive health emphasis.

In order to be a modern visiting nurse, the worker must be a health teacher as well. It is considered, in fact, one of the great assets in visiting nursing work that the actual bedside care given, increases the nurse's opportunity to teach. She demonstrates as she works and the minds both of the patient and the family are in a peculiarly receptive state because of their immediate understanding and appreciation of the definite service she is rendering.

This is found to be particularly valuable in developing the third side of this composite picture—family health work. Actual nursing care to one member of a family opens the door of approach to all the others in that group. To my mind this fact is the most important part and represents the greatest value of the bedside work of the visiting nurse. It gives her a rare opportunity to do health case work with the family as a whole, as her contact is tremendously simplified and strengthened through the obviousness of the nursing service which she renders. It has certainly become a fact well recognized by every visiting nurse that what affects one member of a family affects all the others, and therefore her work can be no longer limited to one individual if it is to be truly effective.

As the work has extended from the individual to the family, it has come to include the community as well. Less and less do we find the work of visiting nurse societies in the hands of small self-contained or self-contented groups who regard it as their pet charity and personal concern. One measure of success of any visiting nurse society is the extent to which it is a community organization. It has an opportunity to educate the community along health lines through a wide participation and sharing in the responsibility for the work. No longer is it considered the concern of a few either financially or in terms of active work. Also its service must be given through the closest relationship with all other organizations and groups. Its position should never be an isolated one but it should have part in whatever means for progress in the social and health conditions of the community. A visiting nurse organization exists for everyone in the community and should aim to serve the health needs of the community in whatever way it can most effectively.

With these principles of work in mind which have been acquired through years of experience, I will try to outline what our present programs might well include if visiting nursing is to take its proper place in community health work.

First, of course, is that which historically had precedence and which still is one of the distinguishing features of visiting nursing work—care of the sick in their own homes, interpreted and enlarged in terms of our present practice. Even this phase of the work assumes a different aspect as we now aim for a community service to the sick on a thoroughly democratic basis with a fee for those who can pay, including an hourly service. Also various restrictions and limitations are rapidly disappearing as certain types of service which we once thought either impossible or too difficult to offer are now included. No longer are we satisfied with just a post-natal maternity service. We aim to have a complete maternity program which means thoroughly scientific and careful pre-natal supervision and instruction, service at time of confinement and a post-natal service that shall include not only care of the mother and baby during the first ten days but health supervision until the mother has had a favorable report after a physical examination. The baby should be kept under supervision until the time comes to transfer it to another Public Health Nurse, such as the child hygiene nurse or school nurse, where these services are separate from that of the visiting nurse.

The astonishingly favorable mortality statistics in the acute cases handled on a visit basis are making this phase of visiting nursing work

loom increasingly large. It is, obviously, because of this that insurance companies feel the economy to them in paying the cost of such service for their policy-holders. Though neither on the side of prevention or health promotion does our work among chronics give us our place among constructive health agencies, I hope the time will never come when we will neglect this humanitarian work. In the majority of cases the actual time the nurse gives can be gradually diminished as she is able to teach some member of the family to give care. Surely such service should be part of the work of an organization that seeks to meet the needs of ghe sick in their own homes. To no troup can we bring more comfort and relief, and their need is doubly great, as these are without hope.

Until recently there has been one phase of sickness that has been sadly neglected, due at least in part, surprising as it may seem, to our sharing some of the superstitions and ignorance of the general public. And curiously enough this condition exists in relation to diseases that offer the greatest opportunity and need for public health measures. I, of course, refer to contagious diseases. By no means has the responsibility for this seeming neglect rested wholly with the nursing profession. Only recently have we had sufficient authority to justify our attempting to cope with this problem outside of hospitals for contagious diseases. Now, however, we have that scientific basis through the generally accepted theory of contact-infection which makes it possible for us to consider the inclusion in our program for the care of the sick, care of contagious cases as well. In view of the fact that, so far as I know, no city is prepared to give 100 per cent hospitalization to all its contagious cases occurring during a given year, it must be honestly faced that large numbers of such cases must be taken care of, adequately or inadequately, at home. Every such case is a potential focus of infection for the other members of the family and the community. To my mind no other situation presents as strategic a point for public health teaching and community protection through nursing care and supervision as these very cases of contagion that remain at home. The very fact that such a service was available would mean both on the part of doctors and families much less concealment of cases of contagion, every such case being an actual danger to others because proper precautions are not taken. Just as now most visiting nurse services already include care of infectious cases such as typhoid, tuberculosis, infantile paralysis etc., so it is entirely possible to administer on a generalized basis a service to all types of contagious cases. This is being done in several cities quite successfully and with the backing of the local departments of health, which is certainly an essential in any such undertaking.

As part of this effort to give the community a complete and inclusive service for the care of the sick, many visiting nurse societies are adding occupational therapy through a staff especially trained for this work. As this subject is to be discussed in a separate paper* at this meeting, I wish only to touch upon it. Certainly the marvellous therapeutic value, both mental and physical, of occupational work suited to the needs and capacities of the individual patient is now beyond dispute. For those of us who have seen what improvement it brings to such cases as arthritis; what interest, hope and encouragement to mental and nervous patients; what real economic value it can have for the slowly convalescing; and what comfort and diversion to those who can have no hope of cure, there remains no question as to the desirability of having such help available for patients at home. There are two ways of carry-

* Published in the September issue of The Public Health Nurse

ing this out, one by having an occupational therapy department as part of the visiting nurse organization, with a specially trained staff who work in the closest co-operation with the nurses in charge of the cases; the other is having a separate occupational therapy organization available for all. This latter method will probably be the ultimate solution when the community becomes sufficiently awakened to the value of such work so that they will support it as a community measure.

Hand in hand with the care of the sick must go a preventive and positive health program for each member of the family. This should include educational work as to prevention of contagious and infectious diseases (I cannot resist making special mention of tuberculosis and venereal diseases); the correction of physical defects; infant welfare and child health work along positive health lines and special application of the latest scientific data and approved methods along nutritional lines.

Granting that the preceding outline presents in the main, though sketchily, the goal toward which visiting nursing is now tending, let us next consider how the work can best be organized to accomplish this end.

Of primary necessity is a board of managers truly representative of the community, which shall feel direct responsibility to the community for the development of the work and who are given an active part in such development. The relationship between such a board and the professional staff should be that of coworkers jointly responsible, each having something definite to contribute that the other cannot give. Therefore they work together with mutual respect, neither patronizing the other but rather with a sense of vital interdependence. In large organizations located in cities, in order that the work may more nearly reflect the local needs and give opportunity for local participation, branch committees have been organized in connection with various sub-stations. Such local subdivisions of the work might almost be regarded as constituting small visiting nurse societies within a parent body, the supervisor of the given station having much the same relation to her branch committee as the superintendent has to the main board of managers. To insure the closest possible relationship between the parent and local bodies, the chairman of the branch committee should sit on the main board of managers, or *vice versa*, a member from the main board be chairman of the local committee. It is interesting to note that one hears fewer and fewer questions as to how such a board and committees may be used. Instead we hear how hard they are working and how closely in touch they are with each new development, not just with the financial side. Too often in the past board members have been thought of as mere money-getters. Now as a professional group, we recognize the fact that if we are honest in saying a part of our work is to educate the community, right within our doors are the representatives of the community, and such education should begin at home. If our relationship is a partnership one, the board should be kept closely in touch with every phase of the work. They should share our hopes and fears—and we theirs. We should always welcome the opportunity to explain our methods and our reasons. Policies should be jointly worked out and the superintendent should realize that if she cannot convince her board as to the wisdom of a given policy she probably cannot convince the public and therefore had better wait. Above all else, she should not go faster than her board are willing to go with her. There are dozens of ways in which the board as volunteer workers can be used and it is worthy of note that active interest follows the giving of practical service. Therefore, the more people there are actually working for the organization, the more widespread will be its understanding and support. Through the subdivi-

sion of the board into functional committees, responsibility for many details such as supplies, dressings and loan closet can be lifted from the professional staff. Also certain organizations have found that a tremendous amount of really careful and accurate clerical service can be obtained from volunteers. Some organizations have developed an excellent motor service from a junior group. In fact there is not time to mention all the ways in which board members and volunteers can be given an active and definite part in assisting in the day by day work.

Of equal importance to a sound basis for work is a staff educationally and professionally prepared. We have heard constantly throughout this convention that our goal, educationally, is at least high school graduation. I do not believe the time has yet come when it is either desirable or practicable to make this a hard and fast requirement, though we certainly give preference to those who have a broad preliminary education. Personally I should feel exceedingly sorry to lose from my own staff, a large number who, while not high school graduates, most certainly deserve the name of Public Health Nurse through the devoted and intelligent health service they are giving to the community. The professional requirements of the National Organization for Public Health Nursing surely should be accepted by all visiting nursing societies as their standard for admission, though even here striking instances of exceptional ability may call for a sufficiently flexible procedure to allow of exceptions. We wish it were possible to make as the third requirement a post-graduate course in public health nursing. Where organizing or executive work is required, especially for the isolated nurse, this is practically an essential. In our larger staffs, however, desirable as it might be, there are neither courses enough or graduates enough to make it possible to have such a requirement. This does not relieve the organization of the responsibility of seeing to it that its staff is properly prepared for the work of visiting nursing—work so different from that done in hospitals or in private nursing. The answer to this dilemma is that organizations should regard their staffs during their first few months as students in training. Many organizations do this through departments of instruction with a Public Health Nurse teacher in charge, giving the new nurses definite lectures, classes, demonstrations and individual instruction. Really, however, neither the staff, nor its executives should look upon this student period as being completed at the end of two or three months. All life is an educational process and certainly in visiting nursing more knowledge and skill is always needed if we are more fully to serve the community. The society, therefore, has a continued educational responsibility toward the staff in order to enable the nurses continually to give a fuller and more constructive service to each family they enter. An adequate and complete service is always the final goal. This educational process can be brought about through the supervisors in conferences with their own branch staffs, through general staff conferences and through making it possible for the nurses to avail themselves of extension courses. It is quite as important educationally, to have the staff organized on a democratic basis, giving ample opportunity for the active participation of every member. No longer is our slogan, "Yours not to question why, yours but to do or die." We *want* our staffs to question. We want them to be using their minds on every policy and method of procedure and we need the benefit of such thinking. In fact these methods and policies should be the result of the group thinking of the staff as a whole, not the decision of the chief executive or even an executive committee. The best way to keep the staff from getting into a rut and careless is for them to have the stimulation of feeling that they are in part responsible

for what the organization does and always have the chance to change it. Such a democratic form of organization at first takes more time, asd oes all democracy, but in the end takes infinitely less time and energy in that the decisions represent the thought of the group concerned and therefore have their understanding and indorsement.

It is rather evident that in this presentation of visiting nursing, it has been interpreted in terms of a generalized service. While this does seem to be the tendency today, it is with the growing appreciation of the contribution that has been and is being made by the specialized groups in the field of public health nursing. The specialist may be thought of as the pioneer, the experimenter and teacher, from whom we may learn new techniques along particular lines, which should be included in visiting nursing as a family health service. It is gradually being recognized that the most satisfactory way of bringing this about is by adding specialized supervisors to the executive staff, such supervisors to act as teachers to the staff as a whole along their special lines. As illustrations of such a supervisory group, the following occur at once to mind: a maternity supervisor; infant and child welfare supervisor; tuberculosis supervisor; contagious and infectious disease supervisor; mental hygiene supervisor; nutrition supervisor. It may be a long way off before any organization can afford all these. As different experiments are tried, it may be found a combination is possible. In any case some such adjustment is certainly necessary if a generalized service is to be inclusive and at the same time thoroughly scientific in all its methods.

The third essential in reaching our goal, granting a representative working board and a democratic participating staff, is a carefully worked-out relationship with other organizations in the community so that duplication is avoided and constructive co-operation actually takes place. Too often one hears a great deal of talk about co-operation and finds very little in action. Usually when one agency says another agency is or is not co-operative, it means that they would or would not do as we wish. Real co-operation, of course, means the actual working together which can best be done by a getting together of the workers themselves whose fields of activity are touching through individual cases or educational programs. If the final objective in such getting together can always be what is the way of getting the best results for the family or the community, rather than the safeguarding of the prerogatives of any individual agency, difficulties will easily disappear. May I reiterate that the conference between the workers involved, rather than the general use of high-sounding phrases, brings more real understanding and concrete results.

There is another possible development in the organization of visiting nursing work about which there is much doubt but yet which cannot be overlooked. That is the use of attendants and of visiting housekeepers in connection with the visiting nursing service. There certainly are times, especially with chronic and convalescent cases, where continuity is a distinct advantage but yet where special skilled service is not required. In such instances an attendant service, operating under trained supervision, would be a great asset. Far more often, however, the need is for a household assistant or visiting housekeeper to take the place of an intelligent mother, who can follow directions in regard to care of the sick during the nurse's absence and will keep the machinery of the household running smoothly for the family as a whole. This whole subject is as yet an unsolved problem, as no organization has been able to work it out successfully over a period of time. In fact it is very debatable whether it is wise or practicable to include such service as part of a trained nursing service, due to the

inevitable confusion that arises. There is general agreement against the organized use of attendants unless the situation is safe-guarded through state licensure. However, the problem in terms of providing care for the sick in their own homes is a real one and deserves mention when we are considering the soundest organization to meet existing needs and conditions.

Out of this brief survey of trends and tendencies, we find that the place of the visiting nurse is right in the center of the whole health movement as a general community family health worker. Visiting nursing exists for the community and by the community to serve its health needs as they arise. If we believe that health ultimately is a state responsibility, visiting nurse associations should be prepared to pass on to the state various phases of the work as fast as the state is ready to take them. There will always be plenty left to be done. It may be in the realm of prophecy, possibly only to be thought of in terms of the millennium, to think of a visiting nurse association as becoming a central community health organization offering every kind of nursing service, including a 24-hour service under trained supervision and central management that will insure uniform standards. In such an organization the kind of nursing service in terms of time given to the patient should be dependent upon the diagnosis and immediate need of continuity and skilled observation and not upon income. At all times and in every capacity, visiting nursing organizations should be the right hand of local and state health departments. Whatever concerns the health of a community is the concern of the visiting nurses of that community. So inclusive and constructive has our aim become that our slogan might well be, "An equal chance for *positive* health."

A DECREASING INFANT MORTALITY RATE

The Statistical Report of Infant Mortality prepared and published by the American Child Hygiene Association is always eagerly looked for.

The Report for 1921 covers 573 cities, and the figures show a very remarkable reduction in infant mortality throughout the country. A comparison of the rates from 1917 to 1921, for cities in the Birth Registration Area, grouped according to population, is given as follows:

Population	1917	1918	1919	1920	1921
Over 250,000	95.4	102.3	87.0	89.0	75.3
100,000—250,000	102.4	113.6	92.2	94.5	77.7
50,000—100,000	102.4	106.3	106.3	94.0	80.7
25,000— 50,000	101.9	109.4	92.6	92.8	81.4
10,000— 25,000	101.3	114.1	94.7	93.8	82.3
All cities	98.6	106.7	91.4	91.5	77.9

In the cities of over 250,000 population, in particular, the decrease is shown. In 1920 there were 8 cities in this group that crossed the 100 line; whereas in 1921, the highest rate shown is 96, and only 4 cities pass the 90 mark. The lowest rate in this group, 48, compares with a lowest rate of 56 in 1920. Surely there is much cause for congratulation here.

A CORRECTION

We regret to find that the address of Miss Adda Eldredge, President of the American Nurses Association, was incorrectly given on Page 431 of our August issue. Miss Eldredge's correct address is: Bureau of Nursing Education, State Board of Health, Madison, Wisconsin.

SOMETHING GOOD IN TURKEY

By JANE HILL

The fame of the nurse has traveled far and wide.

THE only nurse for people in the district of Arabkir, 500 miles in the interior of Anatolia, Turkey, with mountain paths so rugged that the only means of communication is by horseback, is Miss Bessie Murdoch, formerly associated with St. Luke's Hospital, Chicago. For three years Miss Murdoch has been medical director for the Near East Relief orphanage and refugee camps in this district. During this time she has had to fulfill the functions of an executive, nurse and physician, owing to the scarcity of medical workers and the remoteness of the villages.

Probably no public health nurse has worked under greater odds than Miss Murdoch. For months there has been no physician in this district and she has had to treat as many as 100 patients a day, who walked miles to reach the Near East Relief dispensary.

In describing her work Miss Murdoch tells of having to set broken legs and arms, to sew up severe cuts and wounds, and in fact to carry on general medical work. "I have frequently longed to be a physician," she said. "Each morning I wondered what new operation I would be forced to attempt. There were months when traveling was impossible and I had to do my best for these poor people. All nationalities came to me, the Kurd, the Turk, the Greek and the Armenian. I was called to the homes of the rich and the poor, traveling through the lonely mountainous country on horseback.

"When we arrived in Arabkir, we found life so primitive that daily we had to teach new methods of living. For example, there were no combs in the small orphanage we discovered in one of the mountain cities. The children took turns in using the one comb owned by a neighbor."

Miss Murdoch's dispensary had been running for about a year when a young Turkish doctor was sent to the district. Even then, the

officials called in the Near East Relief nurse from America to consult on special cases. Miss Murdoch's fame as a 'doctor' had traveled far and wide. Native girls were her only assistants. They could neither read nor write. However, they made up in willingness and hard work what they lacked in education.

The Near East Relief is now maintaining 38 hospitals besides clinics, and conducts or supervises special dispensary and sanitary work in caring for the health of the refugees and migrant people of the famine and politically disturbed areas of the Levant. Eighty-eight thousand, four hundred and one patients were recorded in the last completed monthly report, and hundreds of people are dying of preventable diseases.

THE EIGHT-HOUR DAY

The executive board of the American Engineering Council, which is the delegate body of the Federated American Engineering Societies, at a meeting in September adopted by a large majority a report presented by Dr. H. E. Howe of Washington, chairman of the Work-Periods Committee, which decided against the continuance of the 12-hour shift, and for the development of the eight-hour day in steel and iron working and other "continuous" industries.

The report resulted from investigations covering a period of nearly two years, undertaken by the Cabot fund for promoting good relations in industry, and the American Engineering Council. The survey included practically all the "continuous" industries, and the following are some of the findings of the report:

"The effect of the eight-hour as compared with the twelve-hour shift operation on the quantity and quality of production, absenteeism and industrial accidents, has been satisfactory where good management and co-operation of labor have been secured. In practically every major continuous industry there are plants which have increased the quantity of production per man as much as twenty-five per cent. In a few exceptional cases the increase has been much higher. Evidence shows also an improvement in quality of production following the reduction in the length of the shifts."

TRUE ROMANCE

All those who wish to realize something of the romance and achievements of medical science during the last few years should read "Map-Changing Medicine," by William Joseph Showalter, in the September issue of the *National Geographic Magazine*. The illustrations accompanying the article are as unusual and picturesque as we should expect them to be in this magazine—and we can say nothing stronger than that.

THE CONSTITUTIONALITY OF THE FEDERAL MATERNITY AND INFANCY ACT

By JAMES A. TOBEY, S. B., LL.B.
Washington, D. C.

THE constitutionality of the Federal act for the "Promotion of the Welfare and Hygiene of Maternity and Infancy" has recently been attacked by the Attorney General of Massachusetts. It has been defended by Representative Towner, one of its authors. These two conflicting opinions, each coming from an eminent lawyer, represent interesting divergences of legal viewpoint on a subject of great importance to sanitarians and those working in the field of child welfare.

The legislature of Massachusetts asked four questions concerning the Federal maternity and infancy act. To the first inquiry, whether it was constitutional, the Attorney General stated that in his opinion it was not. To the second, whether Massachusetts had a right to question the constitutionality of the act, he said that the state had such a right. To the third, whether acceptance of the act by the state would waive its rights to contest it, he declared such acceptance would be inconsistent under the circumstances. To the fourth and last query, as to what procedure should be followed to raise the question of constitutionality, he recommended a suit in equity by the state against the Federal officials charged with its administration.

The Federal Act for the Promotion of the Welfare and Hygiene of Maternity and Infancy, or as more popularly called, the Sheppard-Towner act, became a law on November 23, 1921. The act authorizes an appropriation of $480,000 for the fiscal year ending June 30, 1922 and $240,000 annually for five years thereafter, to be apportioned equally among the states. In addition an appropriation of $1,000,000 for the fiscal year 1922 and a like annual sum for five years is authorized. This latter amount is to be apportioned $5000 to each state and the balance according to population. In order to receive this sum, the state must appropriate an equal amount. The state must also accept the provisions of the act, authorize a state agency to administer it, and submit detailed plans, which must be approved by a Federal Board of Maternity and Infant Hygiene, before the grant will be made to the state. The Children's Bureau of the Department of Labor is charged with the administration of the act and is given not to exceed 5 per cent of the appropriation for such purposes. A certificate of allotment of money to a state may be withheld by the Children's Bureau, with the approval of the board, but the state agency may appeal directly to the President. The board is made up of the Chief of the Children's Bureau, the Surgeon General of the United States Public Health Service, and the United States Commissioner of Education.

This, then, is an outline of the law which Mr. J. Weston Allen, Attorney General of Massachusetts, declares is unconstitutional, and which Representative H. M. Towner, former judge and lecturer on constitutional law, asserts is constitutional. It is our purpose briefly and impartially to review the salient points of these two interesting legal opinions. Neither, of course, has any effect at law. Only the United States Supreme Court can finally pass on the actual constitutionality of the law, and then only when brought before it by the proper parties in an actual controversy involving their rights.

In the first place, after outlining the act, the Attorney General declares that the plans to be submitted by the States are of a nature "wholly undetermined." To this, Mr. Towner

retorts that the act specifically says such plans must be "reasonably appropriate and adequate" to carry out the provisions of the act. The Attorney General describes provisions of the act which he believes give to the Federal Government control over the states. Mr. Towner calls attention in this connection to the concluding section of the act, which provides, "This act shall be construed as intending to secure to the various States control of the administration of this act within their respective States, subject only to the provisions and purposes of this act."

The most important issues, however, are whether Congress can levy taxes for the "general welfare" and whether this law is for the general welfare. Section 8 of Article I of the Constitution states as follows: "The Congress shall have power to lay and collect taxes, duties, imposts and excises, to pay the debts and provide for the common defense and general welfare of the United States; but all duties, imposts and excises shall be uniform throughout the United States." This is the only place in the body of the Constitution where the term "general welfare" is used, though it occurs in the preamble. The Federal Constitution is considered as a grant of power, in contrast to state constitutions, which are limitations of power.

Mr. Allen contends that the words "to pay the debts and provide for the common defense and general welfare of the United States" do not give a substantive grant of power, but merely qualify the preceding phrase that Congress shall have power "to lay and collect taxes, duties, imposts, and taxes." In support of this view he cites several court decisions and quotes from such eminent text writers as Justice Story. He continues, however, that the question does not depend for its answer upon the limits of this power of Congress. He calls the Sheppard-Towner law not an appropriation act, but an authorization for an appropriation which would not be for the "general welfare of the United States," no matter if these words be given the broadest signification.

Mr. Towner, in his speech, devotes some length to the subject of the scope of the general welfare. In construing constitutional provisions, the aim and object, as well as the causes, must be considered. In order to show the purposes of the Constitution, Mr. Towner quotes the preamble, "We, the people of the United States, in order to form a more perfect union, establish justice, insure domestic tranquillity, provide for the common defense, promote the general welfare, and secure the blessings of liberty to ourselves and our posterity, do ordain and establish this Constitution for the United States of America." He then goes on to show by means of historical allusions and quotations from notable authorities, such as Jefferson, Hamilton and Judge Story, that the best view is that Congress has the power to levy taxes in order to promote the general welfare. He further states that hundreds of acts have been passed for this purpose. He regards this as important, as the interpretation given by law-making bodies for long periods of time is among the strongest indications of the intent and purpose of the provisions of a law.

As a further argument, Mr. Towner enumerates those branches of the Government whose appropriations he thinks are only justifiable under the general welfare clause. In this connection he cites the Public Health Service, the Bureau of Education, Reclamation Service, Bureau of Mines, the whole Department of Agriculture, the Smithsonian Institution, and various other bureaus.

One other objection is put forward by the Attorney General. He regards the act as an incursion into the field of the local police power of the states, reserved to them by the Tenth Amendment to the Constitution. The wording of this amendment is as follows: "The powers not delegated to the United States by the Constitution, nor prohibited by it

to the States, are reserved to the States respectively, or to the people." Mr. Allen merely declares this objection and without arguing greatly upon the point remarks that Congress can not assume and the state legislatures can not yield powers reserved to the states in the Constitution. He believes the act would be such an infringement, even though not accepted in Massachusetts.

That "every extension of governmental activity to cure abuses or to relieve untoward conditions has been met with the same objection urged in this case, that it is an invasion of the police powers and the reserved rights of the states," is Mr. Towner's reply. He continues that Congress has used its judgment in such matters, carefully observing constitutional limitations, and has generally been sustained by the Supreme Court. Examples of such decisions as in the Lottery cases, the pure food and drugs acts, the "white slave traffic act," the "prohibition act," and the Sherman Anti-Trust law are mentioned. Other precedents in the nature of welfare legislation made contingent upon acceptance by the states upon conditions required by the general government are also cited. These include the land grant college law of 1862 and the act of 1887 establishing experiment stations at each of these colleges, as well as the law of 1890 providing for more complete maintenance of the colleges; the Smith-Lever act of 1914 appropriating for instruction in agriculture and home economics in the States; the Smith-Hughes act of 1917 granting amounts to the states for vocational education; the Federal road laws of 1912 and 1916 and the recent act of Congress appropriating large sums for highway construction in the states for the next three years. Most of these laws are said by Mr. Towner to be more exacting than the maternity act.

The above review presents the two sides of the argument regarding the constitutionality of the maternity and infancy act. The Attorney General also goes at some length into the method of testing this constitutionality and recommends that the Commonwealth of Massachusetts bring an action in equity against the Federal officials charged with administering the act. Since the United States Supreme Court has original jurisdiction under Article III of the Constitution, of controversies between states and between a state and citizens of another state, he believes it would have to decide the case, if this method of getting before it is proper. Mr. Allen cites a number of cases to show that it is. This is something of a moot point, however. The Federal Government can not be sued without its permission. Where a state sues individuals, such action must generally be brought in a state court, or an inferior Federal court. Appeals from decisions of these courts, where constitutional questions are involved, would eventually reach the Supreme Court.

The Commonwealth of Massachusetts has, through the Attorney-General, actually started such proceedings, by filing a petition with the United States Supreme Court, requesting that the court permit the state to file an original bill enjoining certain government officials from the administration of the Federal Maternity and Infancy Act. This motion comes before the court during its October session, which begins on October 2nd. The disposition of the petition remains to be seen. If it is allowed and the bill comes before the court for trial of the cause, sanitarians will watch the result with the utmost interest and solicitude.

A SIGNIFICANT STUDY*

THE chart prepared by the Babies' Hospital of Philadelphia, which we publish on the opposite page, shows the results of an interesting study of the apparent decrease in the number of acutely ill babies referred to the hospital during the summer months, as compared with the increased preventive work. According to Miss Rena P. Fox, superintendent, during the first three summers of the hospital's existence it was not possible to take in all the babies who applied, and the 60 to 90 beds were filled with the acutely ill. During the last three summers not more than half the beds have been filled at any one time, and many of the babies have been chronic rather than acute cases of gastro-enteric disturbance.

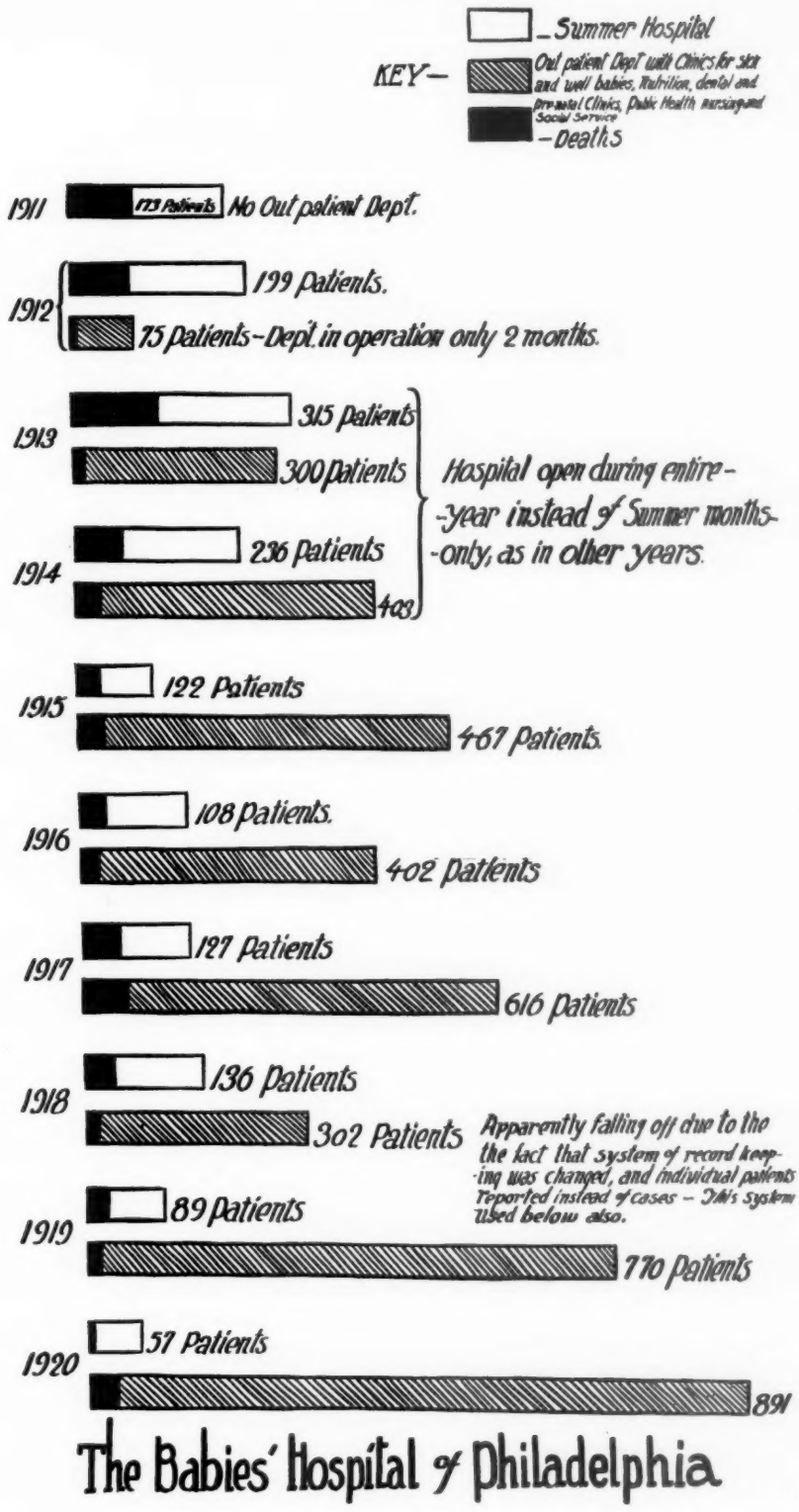
During the last two years charted the summers were not so intensely hot as usual in Philadelphia, and it was felt that this might have had an important bearing on the seemingly improved conditions. Last summer, however (not charted, as the year ended April 30, 1922), in spite of very hot weather the total number of admissions to the summer hospital was only 68, making the hospital bar 1/10 of an inch longer than the last one on the chart; and the dispensary patients numbered 1709, making this bar 8-1/5 inches longer. Deaths at the hospital were 19, and at the dispensary 17.

The deaths represented on the chart are as follows:

1911	Hospital	39%+
1912	Hospital	33%+
	Dispensary	9-1/3% (Only 2 mo. operation)
1913	Hospital	35%+
	Dispensary	2-1/3%
1914	Hospital	30%
	Dispensary	6-2/5%
1915	Hospital	24½%+
	Dispensary	5½%+
1916	Hospital	28%—
	Dispensary	3-1/5%
1917	Hospital	35%
	Dispensary	7%
1918	Hospital	29%
	Dispensary	4-1/3%
1919	Hospital	27%—
	Dispensary	1-7/10%—
192)	Hospital	18%—
	Dispensary	3-9/10%

Deaths listed under Dispensary include all those occurring in children under six years who have at any time been attended by the hospital, regardless of their attendance or non-attendance at the clinics, at time of death. Many of these are from the acute infectious diseases. Those listed under Hospital are all under 3 years of age.

*Illustration by courtesy of the Babies Hospital and Dispensary of Cleveland, Ohio.


KEY—
Summer Hospital
Out patient Dept with Clinics for Sick and well babies, Nutrition, dental and prenatal Clinics, Public Health nursing and Social Service
Deaths
1911
173 Patients
No Out patient Dept.
1912
199 Patients.
75 Patients—Dept. in operation only 2 months.
1913
315 Patients
300 Patients
1914
236 Patients
408
Hospital open during entire-year instead of Summer months-only, as in other years.
1915
122 Patients
467 Patients.
1916
108 Patients.
402 Patients
1917
127 Patients
616 Patients
1918
136 Patients
302 Patients
Apparently falling off due to the the fact that system of record keeping was changed, and individual patients reported instead of cases — This system used below also.
1919
89 Patients
770 Patients
1920
57 Patients
891
The Babies' Hospital of Philadelphia

PUBLIC HEALTH NURSING*

COMPLEXITY OF THE PROBLEM

THE task of analyzing municipal health department practice has proved a sufficiently difficult one in all its aspects; but nowhere else are the difficulties so great as in the field of public health nursing. In the first place we find the activities of public and private agencies overlapping and intermingling in this field to an extraordinary degree; and in the second place different cities exhibit a wide diversity of opinion as to the nature of the work to be performed by the public health nurse.

The original schedule used as a basis for the studies of the committee gave us general quantitative data but in regard to the exact type of nursing work performed by various agencies, particularly that of the private agencies, it was highly incomplete. We therefore supplemented the original survey schedule by a special questionnaire sent out early in 1922 to the visiting nurse associations of the 83 cities studied, asking for detailed information as to the nature of the work performed by all public health nurses employed in their respective cities. Through the courtesy of these associations we were fortunate enough to receive returns from 51 cities giving many of the data in regard to organization and administration required. For general conclusions as to public health nursing service in proportion to population we shall use the official figures obtained by our original survey; but the 1922 questionnaire has given us subsidiary information of the greatest value.

The Extent of Public Health Nursing Service

Public health nursing service of some sort is available in all the cities studied and we have reasonably full data for 80 of the 83 cities.

Grouping together all official and unofficial agencies, there was in 1920 an average of 16.5 public health nurses per 100,000 population in these 80 cities.

The 31 eastern cities with 18.3 nurses per 100,000 population were better provided than the 18 southern cities with 14.3, or the 9 western cities with 10.

The 14 New England cities with 26 nurses per 100,000 population were the best provided. Their superiority is due to the many private agencies which are providing public health nurses in this region.

The usually accepted estimate of a reasonably adequate public health nursing service calls for 50 nurses per 100,000 population. It appears, therefore, that even in large cities there are now only about one-third of the public health nurses needed.

Of our 80 cities, 11 have less than 10 nurses per 100,000, 47 between 10 and 20, 19 between 20 and 30 and 5 cities (Grand Rapids, 30.8; Schenectady 31.6; Bridgeport, 34.8; Boston, 35.7; and New Haven, 36.9) have more than 30 nurses per 100,000 population.

Organization of Nursing Service

In comparing the organization of public health nursing in various cities there are three fundamental respects in which radical differences may be observed; the nursing service may be supported by the municipality or by a private agency; it may or may not include the giving of bedside care; it may be a generalized district service or it may be limited to a particular disease or age or sex. Our original survey indicated that in 76 out of 83 cities some public health nurses were employed by the health department; but in no case was such service provided by the health department alone. In 77

* A chapter of the forthcoming report of the Committee on Municipal Health Department Practice of the American Public Health Association, prepared by C. E. A. Winslow, Dr. P. H., and Margaret R. Burkhardt, R. N.

cities private agencies participated in this work and in many, governmental agencies other then the health department played a part.

Our supplementary questionnaire was particularly designed to facilitate a classification of nursing service under the main heads indicated above. We obtained data for 3699 nurses in 51 cities which indicate the following proportionate distribution, in percentages of the total of 3699 nurses employed. Scattering data for industrial nurses were omitted from this summary on account of their incompleteness.

	Percentage of Nurses Doing Only Instructive Work	*Combining Instructive Work with Bedside Care*		*Total*
	All Specialized	*Generalized*	*Specialized*	
Under public auspices	44	5	6	55
Under private auspices....	7	33	5	45
Total.....	51	38	11	100

Thus in these 51 cities 55 per cent of the nursing service is provided under public and 45 under private auspices, or roughly half and half.

Again we note that about half the nurses confine their work to health teaching (including over four-fifths of those operating under public auspices) while half (including four-fifths of those operating under private auspices) combine instructive work with bedside care. Only 38 per cent of all the nurses tabulated are giving generalized bedside and instructive service.

Two types of public health nursing stand out as by far the most common, the specialized purely instructive work of public authorities (44 per cent of the total), including school nursing, communicable disease nursing, tuberculosis nursing and infant welfare nursing; and the generalized bedside and instructive service of the private organization.

The consensus of opinion among those who have studied the nursing problem most carefully appears to be in favor of a generalized service, combining health instruction and bedside care; and we are ourselves personally convinced that this is likely to prove the most effective of all types of public health nursing. The Committee on Nursing Education appointed by the Rockefeller Foundation in a report presented last June (†), discusses this problem in the following terms:

"The question whether the Public Health Nurse should or should not surrender bedside care has been hotly debated during the past few years. The arguments for purely instructive service rest mainly on two grounds, the administrative difficulties involved in the conduct of private sick nursing by official health agencies and the danger that the urgent demands of sick nursing may lead to the neglect of preventive educational measures which are of more basic and fundamental significance. Both these objections are real and important ones. Yet the observations made in the course of our survey indicate that both may perhaps ultimately be overcome. Several municipal health departments have definitely undertaken to provide organized nursing service for bedside care combined with health teaching, while in other instances instructive nurses, under public auspices, combine a certain amount of emergency service with their fundamentally educational activities. So far as the neglect of instructive work is concerned it results from numerical inadequacy of personnel and can be avoided by a sufficiently large nursing staff.

"On the other hand the plan of instructive nursing divorced from bedside care suffers from defects which, if less obvious than those mentioned above, are in reality more serious, because they are inherent in the very plan itself and therefore not subject to control. In the first place the introduction of the instructive but non-nursing field worker creates at once a duplication of effort, since there must be a nurse from some other agency employed in the same district to give bedside care. In the second place the field worker who attempts health education without giving nursing care is by that very fact cut off from the contact which gives the instructive bedside nurse her most important psychological asset. The nurse who approaches a family where sickness exists, and

† See The Public Health Nurse for September, 1922.

renders direct technical service in mitigating the burden of that sickness, has an overwhelming advantage, then and thereafter, in teaching the lessons of hygiene. With a given number of nurses per unit of population, we believe that the combined service of teaching and nursing will yield the largest results."

Six of the cities studied by us (Akron, Canton, Cleveland, Dayton, Los Angeles and Nashville) furnish examples of what may be considered perhaps the ideal plan for the ultimate future, generalized, instructive and bedside nursing under public auspices.* Where such a combination is impossible on account of lack of public funds or objection to the provision of bedside nursing care under public auspices, the school nursing and communicable disease nursing will naturally be conducted by the city and general bedside care by a private agency. Tuberculosis and infant welfare nursing may be combined either with the former or the latter, best with the latter, on account of the advantageous possibilities of generalized district service.

Types of Nursing Undertaken by the Health Department

It is exceedingly difficult to form any clear picture of the scope of health department nursing work, since it varies so widely in the individual instance. In Akron all public health nursing work (except industrial nursing) is carried on by the health department. In Flint, Nashville, Paterson and Trenton such public health nursing service as is rendered is almost wholly in the hands of the municipality (except for the work of the nurses of the Metropolitan Life Insurance Company). In Kansas City, Kansas, on the other hand, all public health nursing was done by the visiting nurse association in 1920, with a subsidy paid by the city, while in Oklahoma City all public health nursing has recently been placed in the hands of a public health nursing association, financed by the city but administered by a special board representing earlier private organizations which have been merged in it.

Of our 83 city health departments there are 56 which undertake general public health nursing (usually communicable disease nursing in the main); 47 which carry on infant welfare nursing; 46 venereal disease nursing; 45 tuberculosis nursing; and 35 school nursing (in 43 other cities school nursing is under the department of education alone).

The extraordinary variation in the nursing activities undertaken by the department of health in various cities and the lack of any standardized policy is strikingly illustrated by the tabular statement below, in which each possible combination of nursing service is separately indicated:

PUBLIC HEALTH NURSING

ACTIVITIES OF MUNICIPAL HEALTH DEPARTMENTS

	Cities
No nursing	7
General health nursing‡	5
Tuberculosis	1
Infant welfare	2
Venereal	2
General and tuberculosis	4
General and venereal	5
General and infant	2
General and school	4
Tuberculosis and venereal	2
Tuberculosis and infant	2
School and infant	1
General, tuberculosis and infant	2
General, school and infant	3
General, school and venereal	2
General, infant and venereal	2
General, tuberculosis and school	1
Tuberculosis, school and infant	2
Tuberculosis, school and venereal	1
Tuberculosis, infant and venereal	4
School, infant and venereal	1
General, tuberculosis, school and infant	1
General, tuberculosis, school and venereal	2

* This report deals with forms of organization and is quantitative only. In certain of the cities mentioned the actual efficiency of the work performed is seriously hampered by special local conditions.

‡ The term "general" as interpreted by those who filled out our questionnaire does not mean "generalized" nursing in the ordinary sense but usually miscellaneous public health work, including communicable disease control and education.

General, tuberculosis, infant and venereal	8
General, school, infant and venereal	2
Tuberculosis, school, infant and venereal	2
General, tuberculosis, school, infant and venereal	13

In those cities whose health departments conduct specialized nursing we find 2.7 nurses per 100,000 population available for tuberculosis work, 4.2 for school nursing, 3.1 for infant hygiene and 7.5 for general nursing service, (largely communicable disease work).

Health Department Appropriation for Public Health Nursing

It has been estimated by Professor A. W. Freeman that in the future something like one half of the total appropriation of a properly equipped health department will be spent for various forms of public health nursing. At present however, the proportion of the total budget allotted to this service is a very small one. Thirty-nine cities, only, out of 83, report a specific allotment for public health nursing, the average per capita appropriation for this group of 39 cities being 9.5 cents. Seven of these 39 cities report an expenditure of between 10 and 20 cents per capita and 4 an expenditure of over 20 cents (Birmingham, 20.3; Detroit, 22.1; Akron, 23.8; and Utica, 29.2).

Public Health Nursing Under Private Auspices

Public health nursing under private auspices is usually carried on by a visiting nurse association, a district nursing association or a public health nursing association, which is the name now tending to come into greatest favor. In some cities there is of course no such association, although in cities of the latter class there are often private organizations dealing with special problems such as tuberculosis and infant welfare.

The typical plan of the private organization, however, is a generalized district service giving bedside care as well as instruction in hygiene. The cost of nursing service under these private organizations varies from $.50 to $1.43 per visit. The average for 32 cities is $.79.

Co-ordination of the Nursing Work of Different Organizations

Where public health nursing is conducted, as is usually the case, by several different organizations it is most important that some machinery of effective co-operation should be provided. Yet out of 55 cities for which we have such data only 27 report any definite steps in this direction.

Notable examples of co-operation between independent private organizations doing public health nursing are furnished in Indianapolis, Louisville, and Rochester. Co-operation between the health department and a private agency is exemplified in the infant welfare work of Boston, the tuberculosis work of Denver and Omaha and the admirably organized East Harlem Health Center of New York City.

In Cleveland a Central Committee on Public Health Nursing aids in the co-ordination of the nursing work of the department of health, the department of education, the Babies' Hospital and Dispensary and the visiting nurse association. In Dayton the health department and the visiting nurse association are co-operating closely in generalized public health nursing under a single supervisor. In Des Moines the nurses of the health department, the board of education, and the (private) public health nursing association have offices all together in the city hall and close co-operation is effected.

Administration of Public Health Nursing

Among the more distinctly administrative problems of public health nursing, one of the most important is that of supervision. Where nursing has grown up in a health department step by step and in response to specific needs, as has usually been the case, it is common to find nurses working quite independ-

ently under the child welfare division, the tuberculosis division, the communicable disease division, etc. Even if the work of the nurses is to be along specialized lines it is important for uniformity and efficiency that they should operate under centralized nursing supervision, although they may be assigned to various other divisions of the department for their daily service. In 65 cities we have data in regard to this point for health department nurses; 33 have centralized supervision and 32 do not.

The average number of nurses per supervisor under public auspices is 12.4. For cities of over 500,000 population the ratio falls to 11.9 while for cities between 250,000 and 500,000 population it rises to 14.3 and for cities under 250,000 it is 12.3. These figures closely approach Dr. Haven Emerson's ratio of one supervisor to 10 nurses, except for the low figure characteristic of the cities of the second group.

Miss Annie Goodrich, on the other hand, recommends a standard of 6 nurses to a supervisor and we find that the private organizations studied by us approximate this figure with the following actual ratios of nurses per supervisor: cities of over 500,000 population, 6.9; cities of 250,000 to 500,000 population, 7.3; cities of under 250,000 population, 7.1. Another point in nursing administration which we believe to be of real importance in securing maximum efficiency is the provision of sufficient clerical help to relieve the nurses of needless routine. In this respect both public and private organizations are at present generally ill-supplied.

Ratio of Visits per Nurse Under Various Forms of Organization

Data in regard to the work accomplished by the nurses of visiting nurse associations in 46 cities give an average of 1585 visits per year per nurse. Municipal departments naturally show somewhat higher figures, 1693 visits per year per nurse, since purely instructive work is less time-consuming than bedside care. Twenty-six cities whose health department nurses are doing specialized work report 1618 visits and 9 cities whose health department nurses are doing more or less completely generalized work report 1842 visits. In four cities, (Dayton, Des Moines, Nashville and Kansas City, Kansas) where all the nursing forces, public and private, are combined in one organization, 2286 visits per nurse per year are reported.

Industrial Nursing

Prior to fifteen years ago the field of industrial nursing was almost unexplored. The development has been a gradual one, the most rapid progress taking place since 1914. In 1919 there were 871 industries with nursing services supplied by 1213 graduate nurses. With the present industrial depression this number has greatly decreased. In the 83 cities there are now 984 nurses employed by various industries, according to information kindly furnished by Miss Yssabella Waters.

Industries which are so small, or have not as yet felt the need of a full time nurse often employ the visiting nurse associations to look after their employes. In 20 of the cities the V. N. A. nurses do the nursing for from one to thirty industries.

Facilities for Training Public Health Nurses

There are three common ways of training public health nurses. These are: (1) A school of public health nursing, which is usually associated with some university, (2) hospital training schools which give their student nurses short field training under the direction of local health departments or visiting nurse associations, (3) nursing organizations which give new nurses a few lectures by members of the staff and when possible, send these new nurses into the field for a few weeks with the older nurses.

Out of 79 cities for which we have data, 22 report more or less com-

pletely organized courses in public health nursing of 4 to 8 months duration. These include 10 out of the 12 cities of over 500,000 population. Twenty-one cities report less highly developed opportunities for training, in the form of supervised field work or short courses of lectures. In 36 cities there are no educational facilities of any kind.

SUMMARY AND CONCLUSIONS

Public health nursing practice is so diversified, and so inevitably diversified, in view of existing local conditions, that it is difficult to draw general deductions of any kind. A few broad conclusions may perhaps, however, be advanced.

1. Public health nursing service even in our large cities is still notably inadequate in amount, the average ratio of 16.5 nurses per 100,000 population being about one-third of an ideal figure. It is encouraging, however, to note that 5 cities have already more than 30 public health nurses per 100,000 population.

2. The visits reported per year per nurse naturally vary with the type of service rendered, averaging 1583 for private organizations giving bedside care and 1693 for health departments, whose nurses are usually restricted to instructive work. Organizations operating on the generalized plan accomplish a materially greater amount of work per nurse than those where the activities are specialized.

3. While there are all sorts of permutations and combinations to be observed in public health nursing, two types are most common and between them include three-quarters of all the public health nursing of the present day.

They are:

(a) Purely instructive specialized nursing under public auspices.

(b) Combined instructive and bedside care under private auspices.

4. At present most health departments are spending a relatively small amount of money on public health nursing. Only 39 cities report a specific appropriation for nurses' salaries in 1920 and the average appropriation for even these 39 cities is only 9.5 cents per capita. Four cities, however, already spend over 20 cents per capita on public health nursing and it has been estimated that one-half of the health department appropriation may well be devoted to this function in the future. Public health nursing under health department auspices is therefore likely to develop very rapidly in the coming years.

5. The nature of the public health nursing work which is undertaken by the health department varies so widely in different cities as to indicate clearly the lack of any generally accepted standards of policy. The development of such general standards of policy would seem to be urgently desirable, as a basis for their intelligent application to the needs of an individual city.

6. On the one hand, we see a growing tendency to concentrate public health nursing more and more completely in the hands of the official health agencies of the community; and this is a sound and wise tendency. On the other hand, we note a growing recognition of the fact that the ideal type of public health nursing is that which combines instruction and bedside care on the generalized district plan. These two tendencies have been brought into harmony in half a dozen cities where work of this character is performed by the department of health. They can never be completely harmonized, where the city authorities, as is so frequently the case, consider the giving of bedside care as a necessity outside their proper sphere. In such cases a clear understanding should be reached between public and private agencies as to the exact field of each and some systematic machinery for co-ordination should be provided, to avoid, so far as possible, the duplication and friction likely to result.

7. Whether the nursing service of the health department be on the generalized or the specialized plan the supervising of all the nursing work

should, for the highest efficiency, be co-ordinated under a single director of nursing, who should herself be a nurse. This is today the case in about one-half of our municipal departments.

8. Supervisors should be provided in the ratio of at least 1 supervisor to 10 nurses. This ratio is very nearly reached in the average American city by the public nursing organization and is exceeded by the private ones.

9. The efficiency of public health nursing work would in most instances be greatly enhanced by the relief from routine labor provided by an adequate clerical staff.

DISTRICT NURSES IN THE "MOVIES"

When the Providence District Nursing Association asked the people of Providence on Saturday, May 6, for the funds necessary to carry on its work another year, many men, women and children who had never contributed before "dug deep" because they now knew how the work which the district nurses do directly benefits them. The enlightment, and its prolific effect, was accomplished through an exceedingly interesting and appealing photoplay called "Dividends in Happiness," written by the Association's publicity director, which was shown in all the picture houses in Providence the entire week preceeding the Providence District Nurses' annual Tag Day.

With the thread of a story running through it, the film shows how the district nurses are making the community in which they work a healthier and happier place for children to be born and grow up in. The opening scene shows a bond salesman in his office selling a client securities. The latter asks the inevitable question "Will this investment Pay?" and the salesman sug-

The district nurse pays dividends in strong babies

A winning fight against tuberculosis

gests that they lunch and talk it over. As the two men leave the building, they are confronted by a young woman with a collection box and a bunch of tags. The men ask the collector for what the donation is to be used and she answers, "To provide ammunition for our army of district nurses." With the thought of securities still in his mind, the business man jokingly asks, "What dividends do you pay?" but the collector does not take the question lightly.

The scenes that follow picture the collector's explanation of how the district nurses pay dividends to all who contribute in "straight and strong babies, the future citizens of their community; hope and cheer for the discouraged; sanitary homes, a credit to a city; a winning fight against tuberculosis; a safeguard for their families' good health; a healthier, happier, more prosperous community for them to enjoy."

From beginning to end, the picture is a convincing argument for the continuance and furtherance of the splendid work which the district nurses are doing, and shows more forcefully than words could ever hope to do why people should be glad to interest themselves financially in such a worthy endeavor. Every scene is full of human interest, many of them having been taken while district nurses were performing their acts of mercy in homes just as they would do if the camera were not there to record it.

Many of the Providence district nurses appear in the picture, while the roles of the business man, bonds salesman and Tag Day collector were portrayed by Ethelbert Hales, Arthur Hohl and Grace Huff of the E. F. Albee Stock Company.*

* The film can be secured for presentation, from the Providence District Nursing Association, for $50 per week.

THE HISTORY OF PUBLIC HEALTH NURSING*

By LAVINIA L. DOCK, R. N.
Secretary, International Council of Nurses

PUBLIC health nursing, as it is today, in its still incomplete phase of development, has expanded slowly and naturally from that neighborly office of visiting and attending the sick which has been an age-old custom. Springing from spontaneous good will and the gentler emotions, visiting nursing has always been impressed to some extent by the stamp of the special ideals or altruism peculiar to its age, and has also measurably strengthened and disseminated those ideals. When religion held a predominant place in thought, visiting nurse orders or sisterhoods saw, beyond the patient's suffering, a soul to be saved. When humanistic or rationalistic views were entertained, nursing orders became animated by a more freely ranging thought.

As modern science has transformed the medical art, visiting nurses have become infused with a hopeful zeal for a corresponding transformation in the crude adjustments of our physical and social mechanism of living, such as may set free the higher spiritual forces. There has been throughout the ages a certain unconscious democracy of outlook and purpose among those men and women who were the pioneers of public health nursing. It shows clearly in Francis of Assisi; in that revered man, the founder of the Sisters of Charity, Vincent de Paul; and it is unmistakable in the leaders as well as in the rank and file of visiting nurses today.

Florence Nightingale, whose many remarkable writings are too little known, had all through her life the vision and ardor of spirit befitting the first and most eminent Public Health Nurse, though it is as a hospital nurse that she is usually regarded. The phrase "health nursing" was hers, and recurs over and over on many a page in her trenchant printed criticisms and comments on conditions in her day. That phrase was not then understood except by a select few. Preventive medicine was then only beginning to be thought of, and preventive nursing was even more unimaginable. In her long years of work for sanitary reforms in India she impressed the idea of the "health missioner" on the mind of the public, and continued to dwell on the theme in her co-operation with William Rathbone, the philanthropist who founded in Liverpool the first district nursing association on modern lines (1859-1862); in her articles on "Village Sanitation" and "District Nursing," and in her efforts to train an order of "health missioners" as such, in 1890. Her biographer says, "She was possessed by the idea of the district nurse as health missioner."

While many European countries had systems of visiting nursing in the nineteenth century, sometimes carried out under the religious motive, as the Kaiserwerth and other orders of deaconesses, and the Sisters of Charity, sometimes as an expression of humanity in the spirit of the modern Red Cross, England was the first to organize "district nursing," as it was then called, on comprehensive lines, with principles endorsed by modern social reformers. The East London Nursing Society (1868) raised the whole plane of district nursing by requiring that nurses should be educated gentlewomen. Queen Victoria's Jubilee Institute for Nurses, endowed and incorporated by royal charter (1889), created a great national institution for "improved means for nursing the sick poor," lifted district nursing from individual hands, and stands today

* Republished from *A Half-Century of Public Health*, by courtesy of The American Public Health Association.

an eminent model of organization for good nursing in the homes of people. From the initiative of a Queen's Nurse, Miss Amy Hughes, responding to the appeal of a teacher in an English school, the whole modern development of public school nursing has grown up. A touch of caste, however, clung to the English models in their suggestion of charity. Mr. Charles Booth wrote, "Of all the forms that charity takes, there is hardly one that is so directly successful as district nursing." Another weak point was the accepted affiliation with country nursing associations employing "village nurses," who were certified midwives with three months' teaching in district nursing. The best features of the English model were copied by the Dominions: the Victorian Order (1897) covers Canada, and similar societies are at work in Australia and New Zealand.

The Growth of Public Health Nursing in the United States.

The phrase "health nursing" used by Miss Nightingale was expanded to "public health nursing" at the time the National Organization for Public Health Nursing was established.

From 1877 to 1890 district nursing in the United States has been developing in various centers. The Women's Branch of the New York City Mission (1877) worked with denominational limitations. The New York Ethical Society (1879) also sent trained nurses into the homes of the poor, co-operating with the free dispensary movement. Boston first organized on the basis of educational health propaganda combined with bedside care, in the Boston Instructive District Nursing Association (1886). Philadelphia, in 1866, and Chicago, in 1889, discarded the word "district" as meaningless in our cities, and took the name "Visiting Nurse Society" or "Association," as being at once more descriptive and more friendly.

In 1893 Miss Wald and Miss Brewster founded the Nurses' Settlement, as it was at first called, going into the East Side of New York City to live among the people of almost wholly foreign birth. It was the untrammeled and spontaneous character of their enterprise that gave it the inspirational power it has had and still displays. From the first, Miss Wald directed her work and study by the light of a rare feeling for genuine democracy, a determination to bring the best of everything to the service of all.

But she was not alone in this position. Visiting nurses over the country seemed to receive similar impressions, spontaneously and irresistibly, as they pushed farther into paths so different from their hospital work, and as they perceived the conditions that had sent their hospital patients into their care. Poverty must be recognized as a social maladjustment capable of being abolished by intelligent co-operation. It was perceived as the fruitful cause, rather than the result of illness and misery, though there was often a vicious circle. The teachings of science, so plain, clear, and simple, must be accepted as guiding principles. The services of nurse and physician must be as easily attainable by the poor as by the rich, and there must be no exclusion. From this point of view arose the conception of the guardianship of the public health as one of the chief functions of the municipality, the community, the state, the federal government.

Impelled by these vital forces, the nurses of the country often found themselves unequipped for the new fields of service they were entering. The anti-tuberculosis crusade was pressing them to join it as teachers and investigators. It has been said that the leaders of this crusade were the first to recognize the value of the nurse as a teacher of hygiene and sanitation. The public school nursing movement, begun in this country as an experiment by the Henry Street Settlement (1902), spread rapidly over the country and made

extreme demands on the knowledge and qualities of nurses. Big employers had begun to engage nurses as early as 1895. The Proctor Marble Company, of Proctor, Vermont, was the first to employ nurses to conserve the health of their employes and families, followed in 1897 by John Wanamaker, of New York and Philadelphia, with his large mercantile establishments. This was another field of unknown social dimensions. The Metropolitan Life Insurance Company began, in 1909, a system of home nursing for its industrial policy-holders which has grown to vast dimensions. In this service nurses first learned, and with difficulty, how to keep absolutely accurate but complex records.

In 1910 a course in public health nursing was established under the direction of Professor M. Adelaide Nutting at Teachers' College, Columbia University.

In 1912 the National Organization for Public Health Nursing was formed. At the request of some of the leaders in visiting nursing who realized the imperative need of organizing themselves for concerted effort, the American Nurses' Association, formed in 1896 as the Associated Alumnae of Training Schools for Nurses, and the League for Nursing Education, formed earlier as the Society of Superintendents of Training Schools for Nurses, had called a joint committee (1911) to consider the question of standardization for public health work. All existing organizations employing public health nurses, then numbering 1092, were asked to send delegates to form a national organization. The response was enthusiastic, and the purpose of the new society was thus expressed:

"To stimulate responsibility for the health of the community by the establishment and extension of public health nursing; to facilitate efficient co-operation between nurses, physicians, boards of trustees, and other persons interested in public health measures, to develop standards and technique in public health nursing service; to establish a central bureau for information, reference, and assistance in matters pertaining to such service; and to publish periodicals or issue bulletins from time to time in the accomplishment of the general purpose of this organization.

The new organization, while remaining an integral part of the American Nurses' Association, admits lay membership, and has had a most important share in the development of public health nursing. To the energy and devoted service of the first executive secretary, Ella Phillips Crandall, who served from 1912 to 1920, is due much of the effective energy of the organization.

Coincident with the rise of this group came the most potential practical demonstration of public health nursing yet shown, in the resolution of the American Red Cross to found a system of rural nursing (1912). At first begun under the name "Red Cross Rural Nursing Service," it expanded within a year to the "Red Cross Town and Country Nursing Service," and is now the "Bureau of Public Health Nursing." The work thus begun has grown to striking proportions, covering the entire country and involving intricate yet harmonious relations with public health bodies from the smallest to the largest. During the first five years of its existence, made difficult by the cataclysm of war, the Red Cross Town and Country Nursing Service was directed by Fannie F. Clement, whose sympathies and intelligence were exerted to the full in its upbuilding. Her successors, Mary S. Gardner and Elizabeth G. Fox, brought unusual gifts to the service. This Bureau now represents one of the most extensive activities of the American Red Cross.

It may be of interest and importance to note that, as the Red Cross includes on its national committee on nursing the *pro tempore* presidents of the three national nursing associations and other nurses who are prominent in the National Organization for Public Health Nursing, the work of the two bodies may be regarded as largely unified by the guiding influence of the same women

on both councils and both lists of elected officers. With this in mind, the functions and accomplishments of these two powerful societies may be regarded as complementary, embodying both the theory and practice of public health nursing.

When, to this outline of national groups, it is added that many individual societies, such as the visiting nurse associations, and state or municipal boards of health, such as that of Los Angeles, are consciously and purposely carrying out experimental policies with a view to continuous advance in constructive work, and that ever-increasing numbers of educational institutions are opening the way for qualified nurses to receive a special higher education fitting them for the new demands, we shall have said all that the limits of our article will allow on this point.

The Special Branches of Public Health Nursing

In the earlier and simpler days, one and the same visiting nurse encountered and dealt with, as best she might, every form of illness and emergency. But the progress of medical science and, no doubt too, to some extent the rising emphasis laid upon prevention, have brought forward many specialties, whose number seems to increase rather than diminish. The first was tuberculosis. Then followed public school work, child welfare, infant welfare, prenatal nursing, maternal nursing. The usual infectious and contagious diseases form a special problem. To these have now been added the preventive and educational propaganda in regard to venereal diseases. Mental hygiene is a recent specialization whose first primer is just being learned. Industrial nursing is an older specialty, which has not yet, however, become as well standardized and supervised as other branches of public health work. It must involve some acquaintance with industrial philosophies and with labor legislation, which is, in some countries, as Australia, Germany and England, much in advance of ours, though our different states are not without certain codes. Medical social service (formerly called hospital social service) is yet another highly specialized branch of public health work. Dental clinics, especially in connection with public school service, are extending, and every year sees the introduction of one or more specialized lines.

In this multiplication of the specialist nurse, one of the most perplexing administrative questions arises. It is discussed with great clarity and temperateness by Mary S. Gardner in her book, *Public Health Nursing* (pages 70-73), and able arguments are advanced on both sides. It would seem, however, that when left free to develop their work, nurses themselves have experienced a practical compulsion to specialization, and this in considerable degree. The tendency must not, of course, proceed to extremes. It appears, moreover, that the specialist is a leader, or torch-bearer. Where she has first worked alone, her successors can utilize her results in a more generalized type of service. Miss Gardner feels "that to reach the highest possibilities in special lines of nursing, there must be women giving their entire time to these lines, and by so doing becoming experts in them, able to lead others, able to contribute to the literature which is so greatly needed; able, in short, to do for the nursing profession what the specialist in medicine is so successfully doing for the medical profession." While this function of the specialist will always exist, the trend is steadily toward general service of staff nurses, adequately supported by highly trained and experienced experts as consultants or supervisors.

The question of privately administered versus public control is also a controversial one. Here it would seem that the mission of the privately managed society for public health nursing is much like that of the expert specialist, as related to the all-round or general nurse, *i.e.*, it is that of a pathbreaker. In its freedom

to experiment and initiate, it has a valuable contribution to give, in the object lessons and demonstrations it may make, from which public bodies of more routine character can draw fresh advantages. On this point Miss Gardner says:

> From one point of view it is felt that until public health nursing is placed on the same basis as our free educational system, we shall never be really successful in providing adequately for the health of the American people. Others feel that a dual responsibility for the work will always be more desirable, that municipalities or states will never be likely to take the lead in new endeavor, and that unless private bodies still exist to make experiments and bring to bear upon public bodies the weight of a public opinion stimulated by the example of enlightened private enterprise, we shall be in danger of losing a much needed impetus now common where private organizations and a municipality divide the responsibility of the public health nursing of a city between them.

EXTRACTS FROM DISCUSSIONS AT THE RURAL NURSING SESSION IN SEATTLE

"Sometimes it is the unconscious thing that helps sell this work to the people. We very, very often do something that we haven't thought was anything at all and find out that that was the thing that helped the most. I drove out into the country to a mother who had pneumonia—the husband had just died in the sanitarium—I was going for the mother and that was the way we happened to find out that she had pneumonia. It was in the spring, the roads were very bad, mud and slush. I drove out in a buggy and on arriving found that she was quite sick. I stayed all night in the little home of two rooms and did what I could—something anyone would do. I found that this little instance was the thing that made them feel in that community that a public health nurse was worth while."

"There are so many things that will help further the cause, but remember, when you are selling your work to the county, when you are interesting the taxpayers, make them realize that it is something they simply cannot get along without. Tell them how much it will cost per taxpayer—in one county when told it was only ninety-six cents they were willing to pay it."

"We use health posters. We put stories in the newspapers, explaining this work and our methods. We always try to get to the community clubs and interest them in all phases of the work, and then we get the Chambers of Commerce and business men."

* * *

"Sometimes it all depends upon the nurse whether you get it over or whether you don't. If we have something good to offer them and get it over to them we have done well. One great thing that impresses the parents—if you can show them that their child is retarded very often because of ill health, that helps your sales a lot."

THE INCREASED COST OF LIVING

One of our patients has had the V. N. A. for her four babies. When we first found her, she was living in apparent destitution on the west side and we asked no service money. When the second baby was born the family had advanced a bit and we charged 10c a call. With the third baby she was living on Ashland Avenue and we charged 25c. When the fourth child was born, we found her living over a well-supplied furniture store which her husband had bought in South Chicago, and the patient was most indignant when we suggested that she should pay 50c a visit. "Even babies come high," she observed bitterly.

Chicago V. N. A.

VACATIONING WITH THE MAZZAMAS

EDITOR'S NOTE—The following excerpt from a letter of a nurse on the staff of the Portland (Oregon) Visiting Nurse Association, written while taking her vacation with the Mazzamas, should recall past joys to all those of our readers who have ever thrilled to the excitements of mountain climbing, and may perhaps lead some others to seek in the future the delights of such a pastime. The Mazzamas is a club composed of people especially interested in mountain climbing, the qualification for membership being a successful ascent of a snow-capped mountain. The nurses of the Northwest certainly have one great advantage over their Eastern, Southern and Middle-Western sisters: they always seem to have a snow-capped mountain somewhere within reach of a week-end visit. How much many of us would give for just a glimpse of one of those mountains on a hot summer's day!

On the top peak

AUGUST 8, 1922.

WE arrived at Eugene in good shape and had breakfast. We then boarded 16 Dodge cars (5 in a car besides the driver) and rode over good, *bad* and indifferent roads, hot and dust enough to choke you to death. We stopped at McKenzie Bridge for dinner and, believe me, it was some chicken dinner! One of those old fashioned country hotels where they put everything right on the table and you help yourself. From there we drove to Frog Camp, over almost impossible roads, where our car had to go in second gear for six miles in one stretch, so you know what kind of road it was. Then we hiked six miles straight up into the mountains. And a Mazzama mile is a whole lot longer than an ordinary mile. We arrived in camp at 7:30 P.M. and glad to say dinner was waiting.

Next day we took a short hike of six miles, just to limber up. All of our hiking here is up and down, no level spaces. Next day we took a 12 mile hike to Lost Creek and Falls. It was the most beautiful hike and also the hardest I ever made. We crossed meadows covered with beautiful wild flowers—absolutely they cannot be described—you just have to see them. The view from the top of a mountain takes your breath. I fully understand and appreciate the reason Mazzamas love hiking—also know why their emblem is a goat. You need to be a mountain goat to keep up with them.

The crowd is made up of bankers, engineers, clerks, millionaires, etc., all of them congenial and good mixers.

AUGUST 10TH

Didn't finish yesterday so will tell you about the wonderful trip we had. At 7 A.M. we left camp and hiked about 4 miles and then climbed the Middle Sister, an elevation of 10,139 feet. It was a wonderful trip. Everyone stood it finely and all reached the summit. We crossed several glaciers and saw some deep crevasses. Had some good sliding coming down. We made the trip up in 4½ hours and came down in 2 hours. It was great sport. Miss Oleson and I had our pictures taken on the rock that forms

the very top peak (the only women in the party to have that honor); 34 made that trip. If weather permits we will climb South Sister next week. The climb up Middle Sister is not difficult until the last thousand feet, which is rock and straight up. But the view from the top is worth it. We passed through several clouds and could see over into Eastern Oregon. Today is my birthday, and it rained a little so we stayed in camp. Miss Oleson and I had a basin bath with *warm water*. Otherwise, we bathe in the creek. We built a dam so we could bathe. We have just finished playing baseball.

We have a beautiful camp site up on a hill, with a valley below us, where we play ball and have our camp fire. I forgot to say we have one minister with us and he is our patient. He cut his foot while helping us work on the dam and then hiked the next day. Today his foot was badly swollen. We put an alcohol pack on it and will dress it again tonight. You notice it takes two of us to do the dressing.

We have the best campfire parties every evening, singing and stunts. Miss Oleson just brought in a beautiful bouquet of flowers to decorate our camp with.

We get up by bugle and also bugle calls announce the meals. It sounds good as it echoes through these mountains.

The mail only goes out once a week, so it is hard telling when it comes in. There is a box nailed on the tree to serve as mail box and one boy said "Drop your mail in early so I will have time to read it over before it goes out." I am writing this on my knee, that accounts for the unevenness of it. Also, there are so many talking at one time that I can hardly think straight.

Must close for this time as it is dinner time and I couldn't miss it.

GERTRUDE DEUTCH.

POINTS OF A GOOD SHOE

1. An approximately straight inner line from heel to toe. Some feet show an inflare and some an outflare. There are shoes to fit these types. Most feet show a straight inner line and, as a rule, the straight line test for shoes should be applied.

2. Front part of the shoe shall be as broad as the foot for which it is designed.

3. The heel shall not be over 1¼ inches high and shall be as broad on its wearing surface as the human heel.

4. The shoe should fit snugly around the arch and instep of the foot and loosely over the toes.

5. Patent leather shoes should not be chosen because they do not allow free ventilation of the feet.

Rubber heels are distinctly valuable for city wear. The human body developed its structure and functions with reference to an agricultural type of life. While adjustments may be going on in the body fitting it to city conditions, such as hard floors and pavements, it is nevertheless good hygiene to use an appliance such as the rubber heel to relieve the body of jar as much as possible. The relief of fatigue and the increased sense of elasticity are values significant enough to warrant the use of rubber heels.

From Personal Hygiene Applied, by Jesse F. Williams, M. D. Associate Professor of Physical Education, Teachers College, Columbia University, New York City,

THE CONTROL OF VENEREAL DISEASES*

WHAT CAN BE ACCOMPLISHED THROUGH PUBLIC HEALTH NURSING AND SOCIAL SERVICE

By ANN DOYLE, R. N.

Supervising Nurse, Division of Venereal Diseases, U. S. Public Health Service

THE revolution in the attitude of the medical profession toward the venereal diseases has imposed new responsibilities, new obligations on the nursing profession.

When we speak of the change being revolutionary, it may sound a little radical, but to those of us who recall the aversion, the horror, and the indifference with which these diseases were treated by the profession as well as the layman, the change may be properly classed as revolutionary.

It is but a few years ago that serious discussion of them was limited to a few medical men. The very mention of the subject was not alone distasteful to the profession, but any layman possessing any knowledge concerning these diseases or their causes and daring to voice the same was considered a moral pervert, a victim of disease or a mental defective.

It was this very attitude which gave the venereal disease its sharpest sword with which to do damage. Stokes has so impressively written of syphilis, "A disease which in these times of public enlightenment is still shrouded in obscurity and trenched behind a banner of silence and armed by our own ignorance and false shame with a thousand times its actual power to destroy." What has been said of syphilis holds equally true of kindred diseases.

But thanks to a world-wide educational campaign, in which the nursing profession has played an important role, the mantle of secretiveness has fallen, the fight is in the open and it is no longer a disgrace to possess knowledge of these diseases. We can discuss them as freely as tuberculosis, cancer, or any communicable disease; their defeat is only a matter of time.

The conversion of public opinion toward these diseases, and the recognition that the contributing factors, in the person of the keeper of the commercial dance hall, the unscrupulous taxi driver, the lawless hotel keeper, the charlatan and quack and numerous other anti-social agents, should be the target of criticism and prosecution and not the weak individuals who fell victims to the disease, was almost as much of an achievement as the discovery of the organisms of the several diseases.

In the wake of knowledge, however, comes responsibility, and there is no significance attached to the terms social service, follow-up, clinic care, and other nomenclature used in our daily work unless this is supported by intelligent understanding of the entire problem involved.

As less than four years have elapsed since the inception of the national movement for the prevention and control of venereal disease the work may still be considered in its infancy. New facilities for diagnosis, rapidly changing methods of treatment, shifting standards of living, changes in the moral atmosphere, all tend to complicate the situation and make it impossible to dogmatically standardize the modes and methods of dealing with the various phases of this important subject.

It seems fitting therefore instead of telling "what to do" in the abstract, to present in even a kaleidoscopic manner the story of the campaign as it interests nurses.

*Paper read at Session on Venereal Diseases, N. O. P. H. N., Seattle, June 27, 1922.

What then is the task before us? The prevention and control of the venereal diseases.

What are the venereal diseases? Venereal diseases are communicable parasitic infections caused by identified organisms. Their modes of transmission are well known and a practical laboratory technique has been worked out for diagnosis of each one of them. Recent methods of treatment have shortened the periods of infectivity, especially for syphilis, and have offered a prospect of an ultimate recovery.

What is the plan of attack on this problem and how is it formulated? The plan of attack is prevention and control through medical, educational, legal and social measures, promulgated and carried out by bureaus of venereal disease control in the various state boards of health in co-operation with, and under the guidance of the Division of Venereal Diseases in the United States Public Health Service.

The Division of Venereal Diseases of the United States Public Health Service was created through the passage by Congress, July 1918, of the Chamberlain-Kahn Bill, which appropriated more than two million dollars for venereal disease control by state boards of health and the Public Health Service.

Prior to this time there had been no federal effort, and but scant state effort to combat venereal diseases in the United States. Dr. C. V. Chapin, in his contribution to *A Half Century of Public Health: History of State and Municipal Control of Disease* (1921), records for the control of venereal disease the following:

"Venereal Disease Control. There is nothing in preventive medicine more important than this, but until very recently, little has been done. The modern movement against these diseases seems to have begun in California, where, under the leadership of Dr. Snow, these diseases were made notifiable January 1, 1911. By 1915 only a dozen states had made notification compulsory and little attempt was made at enforcing this provision. About twenty-five states were then offering free laboratory diagnosis for these diseases. It was the Great War which chiefly aroused the public to a realization of the tremendous harm which these diseases do and developed a backing sufficient for health officers to attempt what they long knew ought to be done. The State health departments developed the greatest interest in the subject and with the aid of the Public Health Service every state is now carrying on an active campaign and stimulating local communities as far as possible. The chief features of the campaign are notification, the establishment of clinics, the education of the public and the enforcement of all police regulations which tend to make prostitution less easy. Results are already being obtained, but it is too early for any startling figures of wholesale reduction of these diseases."

It can be deduced from this statement that the present national movement against venereal diseases is of very recent origin, dating back less than four years.

From the definition of venereal disease given in the opening paragraph of this paper, one would gather that the Service and the several states had before them a simple task, that all that had to be done was to organize and operate places of diagnosis and treatment and that in a comparatively short time they could retire from the field of venereal disease control. This, however, is not the case. The venereal disease problem is a complex one. It is intimately associated with many other difficult problems, each one of which has in time to be dealt with separately.

Every social and philanthropic agency in a community has, from time to time, brought to its attention for relief or correction some problem in which syphilis is the predisposing factor.

Family welfare secretaries, Juvenile Court officers, child placing agencies and so on, are constantly faced with the difficulty of knowing how to dispose of cases that are complicated with venereal disease and the person who is most frequently consulted is the nurse in some one of her many roles, to assist in formulating plans which will serve to the advantage of the patient and the safety of the public health.

Speaking before a group of physicians in New Orleans, in 1919,

Assistant Surgeon General C. C. Pierce had this to say of the complexity and seriousness of the problem which he and the several state health officers had to meet in planning for a campaign against these serious diseases:

"One almost quakes when approaching the subject of venereal disease control with physicians (and nurses) because it means denuding the whole subject from any emotional appeal, divorcing it from its moral phases and presenting it wholly in the light of hard, cold facts that pertain to the health of a nation. Yet health has so many factors ultimately associated, so many problems of economic and sociologic import involved that one cannot talk of venereal disease control without always keeping in view factors that basically and fundamentally produce conditions that make venereal diseases a national problem of public health as well as a national problem of economic conservation."

A movement having for its object the control of venereal disease should therefore be approached with considerable thought. Such a campaign should normally have been preceded by, and based upon efficient investigation relative to the epidemiological factors of these diseases in the territory to be covered. This would naturally include inquiry into the following points:

1. The prevalence of the diseases with particular reference to distribution; defects in reporting; and hospital or institutional statistics.
2. The economic effects of the diseases.
3. The existing means of treatment and prevention.

However, until the entry of this country into the Great War, statistics as to the prevalence of venereal disease were woefully lacking. Knowledge of the extent of venereal infection was limited almost entirely to a few physicians and utterly unappreciated by the general public.

In the report on *National Vitality: Its Wastes and Conservation*, (1909), despite the fact that the opening sentence reads, "The materials upon which this report is principally based were collected during the last ten years," we find under the chapter on "Prevalence of Serious Illness," but nine short paragraphs dealing with this very important subject. But listen to these paragraphs!

"Dr. Prince A. Morrow says that the number of syphilitics in the United States has been estimated at 2,000,000. This disease is not only in itself a danger, but it also causes a large number of diseases of the circulatory and nervous systems.

Doctor Morrow says that the extermination of social diseases would probably mean the elimination of at least one-half of our institutions for defectives. The loss of citizens to the State from the sterilizing influence of gonorrhea upon the productive energy of the family, and the blighting destructive effect of syphilis upon the offspring are enormous. In the opinion of very competent judges social disease constitutes the most powerful of all factors in the degeneration and depopulation of the world.

Among the troops stationed in the Phillippines, the venereal morbidity during the year 1904 was 297 per 1000, largely exceeding the morbidity from malarial fevers and diarrhea; 22 out of every 1000 soldiers were constantly ineffective from venereal diseases, four times as many as from any other disease.

The statistics of the Navy Department show, during the same year, that venereal disease was chargeable with a percentage of 25.2 of the total number of sick days in the hospital from all causes combined. In four years 949 men were discharged from the Navy for disability from venereal disease. The statistics of the English army show that among the troops stationed in India 537 per 1000 were admitted to the hospital for venereal disease. Of the troops returning home to England after completing their time of service in India, 25 per cent were found to be infected with syphilis.

No statistics exist for venereal disease in civil life. It may be more prevalent than in the army and navy service, since the inhibitory influences of military restraint and discipline do not exist and the opportunities for licentious relations are more abundant.

Neisser, a distinguished German authority, states that "Fully 75 per cent of the adult male population contract gonorrhea and 15 per cent have syphilis."

What syphilis and gonorrhea represent in the lowered working efficiency of our population—to say nothing of the still more important subject of increased mortality—is impossible to estimate; but it would be difficult to over-emphasize the grave danger to national efficiency from these and the other venereal diseases. And here again the most striking point is that the venereal diseases are preventable.

Alcoholism and drug addiction are maladies of frightful prevalence. They are so familiar as to be taken by many as a matter of course.

Venereal diseases and inebriety, whether alcoholic or drug, frequently lead to insanity. Statistics are not yet able to prove conclusively that insanity is increasing, though this is the opinion of the best judges."

You will note particularly the state-

ment made in the above excerpt that, "No statistics exist for venereal disease in civil life, etc." and the statement of Dr. Chapin explains the reason for this state of affairs. Is it to be wondered at then, that when the results of the examinations of the Draft were made public the entire country should have been stunned? Picture to yourself 5.6 per cent of one million men between the ages of 21 and 31, the "Flower of the Land," infected with venereal disease! (This was the second million; the first is rated at 3 per cent, and explanation is made of this in the Provost Marshall General's Report for 1918.)

And this percentage included only the obvious cases of syphilis, gonorrhea and chancroid.

Such figures as these made the nation realize that drastic action was necessary.

It is to be seen from the foregoing explanation why such a preliminary investigation as previously described as desirable was not feasible and why the problem had to be approached from a broad, wholesale, if you please, public health standpoint.

Practically four years have passed since the creation of the Division of Venereal Disease. The effort of the Division has not been the immediate eradication of venereal disease, which was obviously impossible, but has been to co-operate with state boards of health in the limiting of venereal infection. The following figures give an idea of the work done:

Number of Clinics	618
Patients Treated	377,400
Venereal Diseases Reported:	
Syphilis	470,000
Gonorrhea	540,000
Chancroid	32,700
Attendance at Lectures	6,000,000
Attendance at Exhibits	4,000,000
Pamphlets Distributed	19,000,000

These figures by no means, however, tell the entire story. Further results of the effort made may be seen in the fact that the prevalence of venereal disease is now a matter of concern to the thinking people throughout the civilized world.

Through intelligent education, lay, as well as medical, the people have been made to realize that the responsibility for the prevention and control of venereal diseases is not the sole responsibility of physicians, nurses, social workers, and health officers, but is a campaign "of the people, by the people, and for the people."

"It must be evident even to a layman," says Dr. Louis Dublin, speaking before the United States Public Health Service Institute on Venereal Disease Control and Social Hygiene, held in Washington, D. C. in 1920, "that the damage done by venereal diseases is enormous. Most persons now know, in a general way, that gonorrhea is a cause of the sterility of many marriages; the blindness of many newborn infants; the incapacitating of a large number of men for longer or shorter working periods of their lives by acute infection, and later, by chronic invalidism; and the infliction of painful and crippling illness upon hosts of innocent women. Most people know likewise that syphilis is a killing disease; that it is an important causal factor in the mortality of prematurely or still-born infants; that it plays a large part in causing death immediately after birth at full term and during the first year of life; that it frequently produces invalidism and death among young people as well as among the aged through its effect upon the circulatory and nervous systems. It is also well known that syphilis is responsible for a considerable part of insanity and economic incapacity. It is because these facts are generally appreciated that the world is now aroused to combat the venereal diseases."

From the preceding papers you have learned that the work of the Division, in co-operation with the several states, has been carried on through three lines of endeavor, namely, medical, educational and legal, and what has been achieved. You naturally ask yourself, What part did the nurse play in this mag-

nificent program? What specific contribution has been made by her?

Precisely, no one knows. With venereal disease control, as with the control of other big social conditions like the control of tuberculosis and mental hygiene, the nurse has contributed much. Her work is so intimately associated with that of physicians and other agents that a sharp line of differentiation is difficult to draw.

It is noted however that where a clinic or a social service department is under the supervision of an intelligent, sympathetic nurse the work of the physicians and other persons associated with the clinic is of a much higher order and the percentage of lost cases is practically nil.

It is fresh in the memory of some of us what those nurses in the United States Government Clinics in the Extra-Cantonment Zones had to face, and to learn and to do. It was pioneer work, with the emergencies of war aggravated by an ignorance of the task before them, fear of the diseases of which they knew practically nothing and the compelled daily association with women and men of a moral type equally unknown to them.

They not alone had to master the intricacies of the organization of places of treatment but they were frequently the only trained social agent in the community and had to bear the burden of educating the community to a realization of its responsibility for the social and moral conditions which complicated their new task, that of venereal disease control.

Former Surgeon-General Rupert Blue, in a Bulletin prepared for the use of ministers for Health Sunday in 1919, tells those men "What Public Health Nurses did to Fight Venereal Diseases in Extra-Cantonment Zones:"—

"Forty-four public health nurses were detailed to work under forty medical officers in the twenty-seven government venereal disease clinics established by the Public Health Service.

36,000 patients were examined in these clinics and 178,000 treatments given.

They instructed female patients in the care of themselves and the protection of others.

They followed up delinquents.

They assisted in finding sources of infection and in seeking out carriers.

They made social investigations and aided girls in returning to a normal life.

They helped to raise the general health standard of the community by inspection of school children, instruction in the care of all communicable diseases, by detecting new sources of contagion and reporting them, and by recommending new measures of protection against disease."

While these fourty-four were laboring in the Extra-Cantonment Zones many, many others were at work in Army and Navy Hospitals over here as well as over there. Many too were at work in state and city clinics and still others were making daily contributions as visiting nurses and private duty nurses.

For all of them the same report can be made: "They helped to raise the general health standard of the community by inspection of school children, instruction in the care of all communicable diseases, by detecting new sources of contagion and reporting them, and by recommending new measures of protection against disease."

It is to the everlasting credit of the superintendents of training schools, instructors and head nurses that the present day student nurse is so well informed concerning the venereal diseases. The files of the Division show hundreds of requests from such women for help in getting this information to their pupils.

To give some idea of the task before them I can do no better than quote you a few sentences from the testimony of Sir William Osler given before the Royal Commission on Venereal Diseases in the United Kingdom, in May 1915. The question was:

"Would you give us an expression of your opinion as to the methods of teaching medical students? Yes; that is a problem. The question is whether they should be taught in special classes, that is to say, whether the subject should be dealt with under separate division in the curriculum—that is to say, venereal diseases as a subject to be taught systematically in lectures, and systematically clinically; or whether as it is a disease which

boxes the whole compass in medicine, it could not be dealt with more satisfactorily by each person in the different departments dealing with it thoroughly and satisfactorily. The difficulty in dealing with it specially is, that the curriculum is at present so overburdened that I think there is no medical school that would venture to add another special course. On the other hand the subject is very important, * * *

And how very important is seen in a subsequent question—

I see you go so far as to say that the student has to know but one disease thoroughly, and that is syphilis? "Yes, I frequently say to my students: "There is only one disease you require to know thoroughly. Medicine is a very easy art and an easier science. It is the only one in which you have to know a single disease. If you know syphilis, and know it thoroughly, you get all the rest on the way. I mean, you take it as an acute infection in all its local manifestations and there is scarcely an organ which is not involved. If you know syphilis of the eye, you are a first class opthalmic surgeon. If you know syphilis of the ear, you are a good aural surgeon; if you know syphilis thoroughly you are a good gynaecologist, and if you know syphilis of the viscera thoroughly you must be a good medical clinician."

It is true today as in the time of Hosea that "People are destroyed for lack of knowledge." The greatest contribution the nursing profession can make to this important campaign is to inform themselves upon the various phases of this momentous subject and, once convinced themselves, they will consciously and unconsciously make constant contribution, for "Education" is the watchword.

In the last analysis the control of these diseases must come through individual effort. In this movement the adage "A chain is only as strong as its weakest link" is more applicable than in almost any other line of endeavor. The uninfected as well as the infected need instruction, the young as well as the old, the man as well as the woman, the rich as well as the poor.

Because the whole subject is so intimately associated with personal life and private action, much of the social hygiene education must be individual, thus making it much more difficult to disseminate than the usual public health education.

The literature of the subject of syphilis and gonorrhea and their effects, together with their treatment and control, is extensive, more extensive than is generally known. The Abstracts from Recent Medical and Public Health Papers compiled each month from papers, books, reports, etc., are designed to give to the busy doctor, nurse or social worker the best, the most important of what has been contributed.

Therefore, I say inform yourselves. With more than 50,000 well-trained, interested and intelligent nurses it will take no great effort of the imagination to realize what can be accomplished by public health nursing and social service in the control of venereal diseases.

The cost of the fight against tuberculosis in England and Wales has grown from £172,000 ($860,000) in 1914-15, to £1,202,000 ($6,010,000) in 1921-22; but the deaths from pulmonary tuberculosis have decreased from 40,803 in 1915, to 33,505 in 1921, according to the recently published report of the Ministry of Health.

The great decline in tuberculosis in Cleveland, Ohio, in the last few years can be directly attributed to the work of the city's public health nurses, according to Dr. H. L. Rockwood, city health commissioner. Dr. Rockwood points out that there has been a decrease of almost 50 per cent in new cases of tuberculosis since the organization of the public health nursing service.

A WORD FROM OLD KENTUCKY

By ADELE EARLE CUNNINGHAM*
Paintsville, Ky.

PERHAPS there is a tiny corner to spare in THE PUBLIC HEALTH NURSE for a few words of greeting from the old Kentucky hills. And they are such wonderful old hills, with caves and waterfalls, telling of romance and all the mystic histories and feuds of the ages. It is a land of mountains, mining and "moonshine;" yet you almost think of Alice in Story Book Land when you see the quaint log cabins, swinging foot bridges, and ox teams.

One of my first calls on coming here was to one of those little log cabins. It was night, of course, and cloudy and dark. "Doc, he's gone to Flat Gap ten miles away, and the little feller's mighty bad sick."

With a miner's 'carbide' lamp we went what seemed like miles, up and down the hills and across foot bridges. But when the clouds cleared a little you could see the wonderful old mountains one back of the other, and the trees and the river, and you loved it every bit.

And you were glad, too, in that home to nurse the "little feller" and, by the sole light of the open fire place, to do the best that you could until morning and the doctor's return.

Then the people—true-hearted and sincere, yet so greatly in need of help. As you go by boat or on horseback—the only means of travel through many of our winding and precipitous mountain ways—you find poverty and ignorance and disease, and often whole families are found in one-room shacks, sleeping on pallets and cooking over a tiny fireplace. Only last week there was a case where a mother and four children were each seriously afflicted with trachoma and were having hemorrhages from tuberculosis.

The work here is curiously varied, in that, in contrast to the rural part, I have also several small towns, very modern and with all the problems, vices and responsibilities of today. My town and county officials are most co-operative and earnest in their help and there is so much that we want to do. We have already been busy inspecting and weighing school children, testing wells, investigating sources of our numerous cases of typhoid, giving serum and preventive care. We have a prenatal and baby club, and also a venereal disease clinic established with state aid. We do much trachoma work and are expecting Dr. Cobert of Louisville to come to us this fall for a second

One of the first calls was to a little log cabin.

*A graduate of the Army School of Nursing.

clinic. We have also had two clean-up campaigns and have established a permanent system of garbage removal.

We are busy, busy people, but happy in the hearty backing of those in responsible positions, and in the sincere gratitude and love of the mountain folk—like children, mayhap, in their simple and primitive way; yet lovable in their rugged honesty and characters untouched by worldliness.

We need more public health workers. Come and let us show you our beautiful old Kentucky!

The ox teams make one think of Story Book Land.

THE PUBLIC HEALTH ASSOCIATION MEETING

As our readers know, a Provisional Section on Public Health Nursing has been created in the American Public Health Association. The following is a partial program of the meeting to be held by this Section at the forthcoming Annual Meeting of the Public Health Association, to be held in Cleveland, October 16 to 19:

Presentation and Discussion of the Chapter on Public Health Nursing of the Report of the Committee on Municipal Health Department Practice.*
MARGARET E. BURKHARDT, Bridgeport, Conn.

The Co-ordination of Public and Private Agencies in the Conduct of a Completely Generalized Public Health Nursing Service.
ELIZABETH HOLT, Dayton, Ohio.

The Importance of Home Visiting. MARY LAIRD, Rochester, N. Y.

* This Chapter is published in this issue of THE PUBLIC HEALTH NURSE.

HEALTH GUIDE POSTS

By FLORENCE A. SHERMAN, M. D.
State Assistant Medical Inspector of Schools
Albany, N. Y.

EDITOR'S NOTE—We are sure that all our nurse readers know the simple rules laid down below; we are equally sure, however, that they do not always follow them. These "Guide Posts" should not only serve to direct into the right path some of those whose feet have been wandering into by-ways, easier perhaps for the present, but inevitably leading to bad roads further on; but may also be helpful as a simple outline for instruction to those who have not been so well taught.

GET the Health viewpoint.

Have a complete physical examination at least once a year.

Practice daily health habits.

Endeavor to embody and radiate health.

1. SLEEP. Plenty of sleep, from seven to nine hours of uninterrupted sleep, should be assured. Abundance of fresh air should be allowed in sleeping room.

2. BATHS. Take a hot and cold sectional bath daily, on rising. This consists of rubbing the entire body in sections (1) face and neck (2) arms (3) trunk (4) legs. First with a very hot wet cloth, then lightly with one wrung out of cold water. Dry body with rough towel. This is a cleansing and stimulating bath. Reaction is always pleasant. Five minutes should be allowed for it. At bed time, twice weekly, use warm tub bath.

3. FOODS. The human body is a wonderful machine. Irregularity in meals, badly selected foods, lack of careful mastication, disturbs its activities. Foods should be carefully selected, as to values and balance. Leafy green vegetables, fruits, milk, cereals, should play an important part in daily diet.

4. WATER DRINKING. Seventy-five per cent of the body structure is water, which is constantly being lost. It is important that enough water be taken to replace this and wash out body waste. Seven to eight glasses daily are necessary for adults. Not only does it carry away waste, but it lessens fatigue products which are most marked in the last hour of the forenoon and last three hours of the afternoon. The hours for drinking are 11 A.M., 3, 4, 5, P.M. and two glasses during the evening and one on rising. This is an important health measure.

5. MOUTH HYGIENE. Visit your dentist every six months in order to prevent trouble. Practice daily mouth hygiene, at least night and morning. Use a medium stiff toothbrush and a good dental cream. Always rinse the mouth carefully after brushing, with warm water or some mild antiseptic solution.

6. FRESH AIR. Get plenty of it day and night. Take some outdoor exercise daily—at least one hour a day is desirable. Take a sun bath whenever possible. Practice deep breathing. Take at least six deep breaths, exhaling slowly. Repeat this at least six times during your outdoor hour.

7. TOILET HABITS. Regular toilet habits are imperative to health. One daily movement at least should occur. Definite times for visiting the toilet are important. Always in the morning and possibly at bed time. Irregularities should receive prompt attention. Regular habits do much to keep this function normal.

8. REST. Rest for at least ten minutes during noon hour. Lie down if possible and relax. Remove clothing and lie down for an hour or half an hour before supper or dinner.

9. RECREATION. Recreation is essential to health. A good play, movie, concert, dancing class or card party once a week is a good investment health wise, mentally and physically.

Recreation in the open should be

taken whenever possible. Walking is one of the best forms of exercise.

10. POSTURE. Normal poise of body in standing, walking and sitting is necessary for health. Normal functioning of body is impossible without this. Sensible, healthful clothing is a requirement for good posture. Avoid tight clothing; wear sensible shoes. Shoes with low, broad heels, flexible shanks, straight inside lines, which allows plenty of toe spread.

11. BREATHING. Few people breathe properly. This affects seriously normal bodily function. Breathing should be unhampered by restricted clothing. Deep breathing should be practiced daily; particularly in the open and upon rising and retiring, before open windows. Eight or ten good deep breaths, several times daily, will aid circulation and increase bodily resistance.

12. CHEERFULNESS. Absolutely essential to bodily vigor. A duty to ourselves and to others—strive for it.

A FURTHER NOTE FROM WYOMING

In our July issue we published a record of "County Nursing in Wyoming" by Rosemary Kellner of Rawlings. Miss Kellner spoke in her paper of nutrition work which they were just beginning in schools of the county; we have now had a further letter from her in which she gives the following interesting notes about the success of that work:

"You may be interested in the returns on my nutrition work in the schools of Rawlings, Wyo. It was not nutrition work, as it is generally conducted, for there was no physician in attendance. The following results were attained just through efforts of the children themselves and not always with much co-operation at home.

This group of children with whom I worked ranged from 14 per cent to 30 per cent under weight. I carried 20 of them over a period of 3 months. 6 of them made only the required gain per month as indicated by charts by Dr. Wood, but did not reduce their per cent under weight. The remaining 14 reduced their average per cent under weight by ⅓ (33 per cent). It seems to me that is a pretty good record, when you take into consideration the fact that hot cakes for breakfast and a great deal of fried food is the rule, and where vegetables are scarce and expensive.

These children received a mid-morning cup of milk at school, most of it paid for by the recipient at cost price. The deficit at the end of each month was met by the various women's clubs in the city, who were more than ready to help."

WOMAN'S CLUB HEALTH PROGRAM

Mrs. J. R. Brandrup, Chairman of the Public Health Committee of the Minnesota Federation of Women's Clubs, has submitted the following as the work outlined by the Division of Health of the Federation:—

1. A Public Health Nurse in every community. At present there are fifeteen counties without health nurses, though the legislature has authorized the county commissioners to employ such nurses at the county expense. In several instances, the commissioners have refused such action though urged to do so. As full citizens and armed with the power of the ballot, the women now have it within their power to demand that a nurse, the greatest influence known in awakening the health consciousness of the community, and in educating the people in health conservation, be at once employed.

The Minnesota Heath Journal

ACTIVITIES
of the
NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

Edited by ANNE A. STEVENS

EXECUTIVE COMMITTEE MEETING

The first meeting of the newly elected Executive Committee was held the 18th and 19th of August.

New Committees

One of the first duties of this committee, immedately after the Convention, is that of approving the nominations made by the President for the Chairmen of the various committees. The personnel of the standing and special committees will be published as soon as they are approved by the Executive Committee.

Finances

It was voted to send a copy of the following resolution and an extract from the President's report which explains the financial situation of the National Organization to every nurse member, during September.

Whereas, in the past years of our development the major share of our financial support has come from a few large contributors,

Whereas, we believe a more widespread understanding of our ideal and policies is necessary, and

Whereas, this can only be secured through a more general participation in all our activities, including the financial support,

Be it Resolved That we, the nurse members, express to our Committee on Finance a desire to take a larger share in this support, and recommend that:

1. Our present dues be maintained;

2. Each nurse member be requested to secure one annual ten dollar contribution and in addition, be given opportunity to make such personal contribution as her income warrants.

Branches

Any state organization wishing to become a branch of the National Organization as provided for in Article XV and XVI of the By-Laws is requested to send its constitution and by-laws to the General Director. A committee has been appointed to study such constitution and by-laws and to make recommendations to the Executive Committee regarding the approval of state organizations as branch s.

State Committees

Inasmuch as from a nation wide standpoint little success has attended the tremenduous effort made by the Chairmen of the State Committees of Friends of Public Health Nursing, it was decided to seek some other method of stimulating membership and to discontinue the work of these committees which have consumed effort out of all proportion to the results obtained. It is hoped that the effort made by every nurse member to interest at least one member of her community in the work of the Organization, may result in an increase in the membership and that a similar increase in membership, both nurse and sustaining, should follow the development of state organizations.

Miss Hodgman returned from her long trip and will have attended the meeting of the Educational Committee and set forth again before this issue of the magazine comes from the press.

SO THIS IS HEALTHLAND

By Cliff Goldsmith

SEVERAL months ago the National Dairy Council asked the National Child Health Council whether its member organizations, of which the National Organ-

ization for Public Health Nursing is one, would exhibit at the dairymen's annual exposition. The National Dairy Council agreed to pay all expenses connected with such an exhibit. After careful consideration, the National Child Health Council accepted the invitation and the result is *Healthland*, conceived and staged by Cliff Goldsmith of the Child Health Organization of America and the National Child Health Council, and executed by Martin Jenter, of Artcrafts, Mount Vernon, N. Y.

About the time people supposed everything on earth was discovered—that was discoverable—somebody began poking around and ran into a new country. That was about June 1, 1922.

Ever since then the explorers have been digging around and unearthing new buildings—at least things that looked like buildings. (One has walls built of delicious tomatoes, juicy oranges, and even ice cream! When the excavators finally reached the entrance to this queer house, lo and behold, there were two tables just inside all set for dinner. And there was everything there that even a good fairy could possibly want a boy or girl to eat). A castle, too, was found with real knights riding cows, and bathtubs, and such things, on the castle's front lawn.

An inviting book shop has been discovered with walls all built of books. Even the shutters of the shop are large magazine covers. A great owl of wisdom looks down from the top approving all who enter and read the books written for nurses and mothers, and teachers—in fact, all folks, who wish to be healthy, happy and wise.

And one day they found a building made of gold coins—a bank where boys and girls are deposited until they are grown up. While they are there, their minds are invested in paying educational schemes—and their bodies protected from greedy profiteers. You see, in this new country, wealth is health—and everybody seems to be a millionaire.

In and out among the houses runs a railroad—a real railroad, with a real train, and the name of it is the Child Health Railroad. Twenty-seven boys and girls may ride on it at a time on a sight-seeing tour through this new country. The engine's back is scarcely as high as your knees. Of course one must have a ticket, and the way one purchases that ticket is by telling the conductor his age—his height—and his weight.

We must tell you about the baby garage. It is built just like an over-grown kiddie coop. Here, however, babies are not repaired—none need it. The baby garage merely keeps its customers in running order and supplies them with free air.

The excavators are still digging. Just yesterday they found a beautiful art gallery filled with pictures—and they were drawn as only the artists of such a funny country draw them.

At present a theatre is being uncovered which seems about as nice as any theatre on record. The film that is playing there is all about a baby that becomes president of the country. Of course a baby couldn't really be president if it weren't for the fact that there are no strikes or dull seasons or conventions amongst his people. Everybody seems quite healthy.

So far no candy stores have been found. A refreshing milk bar was unearthed the first day. But that is only natural. It is the first place everybody goes anyway. There is also a fortune teller's tent where folks drop in every now and then. The Ouija board is fastened to the platform of a pair of scales. Unusually strong animals have been found in the zoos. Their main diet seems to be milk.

Now you wonder what country it is that has just been discovered. In the language of the natives it is known as Healthland, which in English means, the Land of Health.

And where is it?

That is hard to say. The entrance is at the Minnesota State Fair Grounds, between St. Paul and Minneapolis. It is said that if interest continues, Healthland may be found to spread all over our country.

When may you really see it?

Well, the explorers hope to finish their work by October 7th and it will be a fitting spectacle for the National Dairy Show, which lasts from October 7th to 15th. The surprises which may be uncovered between now and the formal opening are unlimited. At this very minute steam shovels are trying to pry loose a wireless station. For centuries this radio station has been attempting to make a contact with the United States. The message which it has is urgent.

The explorers co-operating in this work are:

U. S. Bureau of Education
U. S. Children's Bureau
U. S. Public Health Service
National Child Health Council
American Child Hygiene Association
American Red Cross
Child Health Organization of America
National Child Labor Committee
National Organization for Public Health Nursing
National Tuberculosis Association
University of Minnesota
Parent Teacher Association
Dr. E. V. McCollum
National Dairy Council

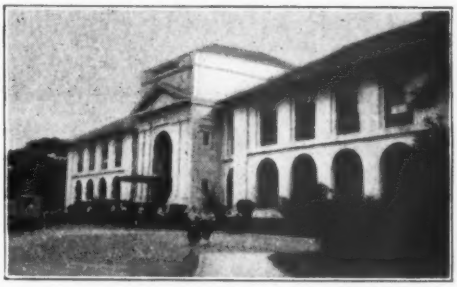
A PUBLIC HEALTH NURSING COURSE IN MANILA

An announcement has just reached this office of a six months course in public health nursing which opened in Manila August 1st. The course

is being offered by the Phillipine Health Service in co-operation with the University of the Philippines, the Philippine General Hospital, the Bureau of Public Welfare, the Red Cross and other charitable and philanthropic organizations in Manila. Miss Giron, Philippine General Hospital, who took her post graduate public health nursing work in the Pennsylvania School of Social Work, Philadelphia, is in charge, assisted by Miss Virginia Gibbes of the American Red Cross. Miss Alice Fitzgerald is the adviser to the course.

The theoretical and practical work is planned on the basis of courses now being given in the United States.

There is a plan on foot, under Miss Fitzgerald's direction, for a central school of nursing in Manila.



Philippine General Hospital

The school plans to offer an elective course in public health nursing for its senior students.

News of the starting of courses in public health nursing are coming in to this office frequently with requests for advice. In the last six months we have heard from Turkey, Russia, Poland and Serbia.

COMMITTEE ON EDUCATION

It has been decided to discontinue the New Haven course in Public Health Nursing for the coming year. The course at the University of Pittsburgh is without a Director and will not be open until the position is filled.

The Public Health Nursing course at the George Peabody College in Nashville is resumed this fall under the direction of Miss Abbie Roberts.

Miss Helena Zurawski is directing a course in Public Health Nursing in connection with the University of Cincinnati.

Word has been received in this office that scholarships for Educational work which are being offered by the Estate of Laverne Noyes, 2500 Roosevelt Road, Chicago, Ill., are open to nurses who served in the Army or Navy during the war. It is hoped that some of these scholarships may be used by nurses desiring to take post-graduate courses in Public Health Nursing.

CO-OPERATION (DEFINITION)

Tony was the housekeeper during Mother's rest in bed after the arrival of the new baby. After listening to the nurse's instructions for preparations for the next day's visit, Tony was determined to be ready. He arose at 5:30 the next morning and set two kettles of water on the stove to boil and when the nurse arrived at 8:30, the kettles were both dry!

Chicago, V. N. A.

LIBRARY DEPARTMENT—BOOK NOTES

Edited by A. M. CARR

HEALTH AND EFFICIENCY

By Thomas Darlington, M. D.

Wynkoop-Hallenbeck-Crawford Company, New York 1922. $1.50.

The author, a former health commissioner of New York City, has written an interesting book on personal hygiene for the layman. It presents scientific facts shorn of technical language. The twenty-four chapters deal with such subjects as Air, Drinking Water, Food, Movement of the Bowels, Getting Tired, Sleep, Clean Hands, Baths and Bathing, Exercise, Clothing, Sunshine, How Insects Carry Disease, and the Influence of Mind over Body. Chapters are also devoted to the care of special organs, as hair, eye, ear, nose and throat, feet, mouth, teeth, heart and blood vessels. The layman who reads this book would learn much that he should know about himself and the care of his health.—J. A. T.

Note: Because of the author's wide experience with factory groups, this book will offer many suggestions to industrial nurses who find the preparation of health talks somewhat difficult.

OPIATE ADDICTION—ITS HANDLING AND TREATMENT

By Edward Huntington Williams, M. D.

The Macmillan Co., New York. Price $1.75.

Most of us (speaking of nurses) need all the light that can be thrown on the subject of drug addiction. We realize however that it is often difficult to know the true value of the printed information that, in the form of books and pamphlets, comes to our notice. "Where doctors disagree," as undoubtedly they do on this subject, where can we take our stand? And yet the widespread use of narcotics, to which we cannot and must not shut our eyes, brings to public health nurses the same responsibility as other problems of public health.

Dr. Williams' book on Opiate Addiction takes, we believe, a fair attitude towards the problem as it is viewed today, and should be of distinct assistance to students of the subject. The introduction gives a good picture of the phases through which this most piteous of our ills has passed. The chapters cover Handling and Treatment of Opiate Addiction, General Reduction Treatment, Rapid Withdrawal Methods, Useful Hypnotics and Comments and Observations.

Note: In connection with this book the following reference to the correct usage of the word "drug" will be of interest:

"Headline writers are often forced to use short words, the definitions of which may not supply the exact meaning desired. This is one of the reasons that the word "drug" is used so commonly in place of the word "narcotic."

The Pacific Drug Review has called the attention of the State Board of Health to this matter, and we believe that the Review is right in its contention that the word "drug" should be eliminated to the greatest possible extent in all publicity material relating to the narcotic addict situation."

COURAGE

By James M. Barrie

Scribner. 1922. 60 cents.

MANY are the virtues and the qualities expected—nay, demanded—of those who elect to follow our old and honorable calling. Some will say one thing, some another, what virtue, what quality is the most desired or the most complete. But one there is without which none of us (with credit to our exacting inner selves) can pull through the hard places, the lonely hours, the doubting moments.

Read this tiny volume which holds, as in a precious cup, the golden

message of one of the most beloved of men. It is the Rectorial address delivered by J. M. Barrie to the students of St. Andrews University. The name on the title page is Courage. "It is the lovely virtue—the rib of Himself that God sent down to His Children."

MOTION PICTURES FOR COMMUNITY NEEDS

By Gladys Bollman and Henry Bollman

Henry Holt & Co. 1922. $2.00.

This book is a practical manual of information on the use of the motion picture by educational, religious, and social workers. The authors have succeeded in gathering and presenting, in very readable form, such facts as will help the non-professional movie person to procure and present the best moving pictures of the day before non-theatre community audiences.

A list of exchanges is given, 100 programs are suggested, and advice is offered with regard to equipment, installation, and the operation of machines, as well as the actual laws relating to the exhibition of motion pictures.

It would appear that every library in a community alive to the value of motion pictures as a means of education, should have a copy of this book available for its workers.

A. K. B.

The following information was distributed in sheet form from the National Organization for Public Health Nursing booth at the Seattle convention exhibit. Copies of this list of distributors of educational moving pictures may still be secured from National Organization for Public Health Nursing Headquarters.

To The Public Health Nurse:

In putting on a Health Campaign in your local community, or in emphasizing a particular health need, a good motion picture can be of great value. Helpful films can be secured from the following associations. When inquiring about available films, communicate directly with these associations, because their rental terms vary.

American Red Cross (Distributed by Society for Visual Education. See below).
American Social Hygiene Association, 370 Seventh Avenue, New York, N. Y.
American Society for the Control of Cancer, 370 Seventh Avenue, New York, N. Y.
Federal Children's Bureau, Washington, D.C.
National Board, Y. W. C. A., Bureau of Social Hygiene, 600 Lexington Avenue, New York, N. Y.
National Committee for the Prevention of Blindness, 130 East Twenty-second Street, New York, N. Y.
National Organization for Public Health Nursing, 370 Seventh Avenue, New York, N. Y.
National Tuberculosis Association, 370 Seventh Avenue, New York, N. Y.
Society for Visual Education (Also distributes Red Cross films), 327 South La Salle Street, Chicago, Ill.

The Modern Health Crusade manual for 1922-23 has just been published and can be ordered from the National Tuberculosis Association, 370 Seventh Avenue, by sending eight cents in stamps. In addition to courses for kindergarten and primary grades there is the Advanced Course for seventh, eighth grade and high school groups.

The new features that will especially appeal to nurses are the "Nutrition Chores" and the "Record and Chart for Weight Lines." Also the bibliographies on the last two pages suggest a wealth of good reading—stories, songs and primers.

"The Widening Field of Public Health Education," from the New York State Public Health Nurses Bulletin for last April, has a word of interest for other readers than those in New York:

"Modern nutrititians assert that we do not eat enough milk, greens, fruit and fresh vegetables. These foods are costly in winter, and in rural districts where they are usually abundant in summer they can not be purchased in winter * * * The public health nurse who participated in a canning bee where greens, tomatoes, and other essential foods were being preserved had the satisfaction of knowing she was "right on the job" of public health education. Good individual health is no will-o'-the-wisp. It is a reality which can be possessed, but to start it with the newborn baby is to begin too late. The newer methods and avenues of approach call forth interest and effort where formerly only indifference was encountered. Public health nurses can not

greatly change the home environment, but if they are wise enough and sufficiently resourceful, especially in utilizing, and working with other people, they may help to arouse an interest which will result in the home people changing their own environment or making adjustments which will overcome its disastrous features. This is the aim of all education."

NEW REPRINTS

Those who attended the Seattle Convention as well as those who did not will be glad to know that the Library will have reprints of many of the papers that were read and are now appearing in THE PUBLIC HEALTH NURSE and the *American Journal of Nursing*. Among them will be Dr. Lucas' "Normal Development of the Child" and Dr. Hedger's "Discussion," which as she announced, was not a discussion. Its reprint title will be "Positive Health for Nurses—an Ideal." Also Miss Allen's "What Should Constitute a State Program for Public Health Nursing."*

"Public Health Nursing Service in a State Department of Health," is a recent addition to the reprint service. Written by Dr. Robert A. Paterson, of Ohio State Public Health Association, and published in the *American Journal of Public Health*, August, 1922, it calls to mind Miss Rose Ehrenfeld's article in the March issue of the same magazine: "The Relation of Public Health Nursing to other Phases of Work of State Boards of Health;" and of Miss Jessie Marriner's outline of August, 1921: "Functions and Relationships of Bureaus of Child Hygiene and Bureaus of Public Health Nursing." Unfortunately reprints of the two latter are not available but copies of Dr. Patterson's article may be had at 5 cents each.

NUTRITION

Nutrition workers will have much "food for thought" if they take advantage of all that is now being published for their benefit. Among the new pamphlets are two from the New York Association for Improving the Condition of the Poor:

A Method for Determining an Adequate Minimum Food Allowance: with fifteen points for the social worker who has to deal with nutrition problems.....$ 0.35

Height and Weight as an Index of Nutrition; including practical instructions..... .35

As a reminder, may we also list the other two older pamphlets, even though they bear the publication date of 1917:

Survey of Evidence regarding Food Allowances for Healthy Children. Gillett..... .10

Adequacy and Economy of Some City Dietaries. Sherman and Gillette.... .25

The National Health Library has prepared the following list of books which public health nurses may wish to recommend to their local libraries for purchase. Copies of the list may be obtained from Miss Bradley.

SOME RECENT BOOKS ON COMMUNITY HEALTH

ATKINSON, C. E.
Lessons on Tuberculosis and Consumption for the Household; showing how to prevent tuberculosis, how to recognize its first symptoms, how to win back health.
Funk & Wagnalls, 1922

BAKER, S. JOSEPHINE
Healthy Mothers
Healthy Babies
Healthy Children
Federal Publishing Co., 1921

BEERS, C. W.
The Mind That Found Itself: an autobiography (revised edition).
Longmans, 1921

BURNHAM, A. C.
The Community Health Problem.
Macmillan, 1920

CLARK, W. I.
Health Service in Industry.
Macmillan, 1922

DAVIS, M. M.
Immigrant and Community Health.
Harper, 1921

DREVER, JAMES
Psychology of Every day Life.
Dutton, 1920

HOLT, L. E.
Food, Health and Growth: a discussion of the nutrition of children.
Macmillan, 1922

MCCOLLUM, E. V.
Newer Knowledge of Nutrition: the use

*Published in the September issue of THE PUBLIC HEALTH NURSE.

of food for the preservation of vitality and health (revised edition).
Macmillan, 1922

MARCH, N. H.
Sex knowledge. Dutton, 1922

MAY, J. V.
Mental Diseases: a public health program.
Badger, 1922

OSLER, SIR WILLIAM
Evolution of Modern Medicine.
Yale Press, 1921

POPE, AMY
Textbook of Simple Nursing Procedure for High Schools, together with instructions for first aid in emergencies.
Putnam, 1921

RAVENEL, M. P. ed.
Half Century of Public Health.
American Public Health Ass'n., 1921

ROSENAU, M. J.
Preventive Medicine and Hygiene (revised edition). Appleton, 1921

ROYDEN, MAUDE
Sex and Common Sense Putnam, 1922

STOKES, J. H.
Third Great Plague: a discussion of syphilis for every day people.
Saunders, 1917

WITH THE BRITISH JOURNALS

A recent issue of *The Queen's Nurses' Magazine* gives a summary of the 1921 Report of Queen Victoria's Jubilee Institute for Nurses. The report shows that at the end of last year there were 1147 Nursing Associations in affiliation with the Institute, which were employing 2035 Queen's Nurses. There were also 50 affiliated County Associations employing village nurses and midwives, the total number of nurses in connection with the Institute being 5478 * * * The report states that there has been an increase in the number of nurses applying for training, and that the standard of the candidates is good.

"The more Memoirs which appear about Miss Florence Nightingale the more the old ineffective philanthropist fades from the picture, and the more distinctly the magnificent militant figure stands out. Read Stephen McKenna's keen and interesting 'While I Remember' and Shane Leslie's 'Life and Labours of Cardinal Manning,' where an entire chapter is devoted to 'Florence Nightingale and Others.'

"This woman of genius was never a shadowy saint, but one of the most relentless protagonists of her time, using her tongue and pen in ceaseless warfare in her struggle against the hydra-headed evil of ignorance. As truth comes to light we begin to realize her suffering. Inspired by the white flame of vision, what agony she must have suffered in attempting to make the blind see, the dumb articulate, the *fish* feel!

"And in revenge, obscured by 'the two black spots,' she remained 'a dear, sweet saint' for seventy years!"

Excerpt from
The British Journal of Nursing
June, 1922.

The Nightingale Shore Home, the new home of the "Queens Nurses" in London, was opened in July. From the description in the *British Journal of Nursing*, it must be a charming place. The memorial room to Miss Nightingale Shore has at the door this old Gaelic Rune "recovered" by Kenneth McLeod:

RUNE OF HOSPITALITY

I saw a stranger yestreen;
I put food in the eating place
Drink in the drinking place,
Music in the listening place,
And in the sacred name of the Triune,
He blessed myself and my House,
My cattle and my dear ones.

And the lark said in her song,
Often, often, often,
Goes the Christ in the stranger's guise,
Often, often, often
Goes the Christ in the stranger's guise.

Printed copies of The Report of the Committee on Nursing Education, made by Miss Josephine Goldmark under the direction of the Rockefeller Foundation, can be secured from the office of the National League of Nursing Education, 370 Seventh Avenue, New York City. Price 15 cents per copy.

RED CROSS PUBLIC HEALTH NURSING

Edited by ELIZABETH G. FOX

THE FIRST DELANO RED CROSS NURSES

TWO of the nursing services made possible through the fund left by Miss Jane A. Delano for the establishment of public health nursing in localities which would not otherwise be able to afford a community Public Health Nurse are now under way.

Stella M. Fuller, formerly assistant director of public health nursing in the Southern Division of the Red Cross, is beginning her work on the Alaskan Peninsula. Her headquarters are at Seward on beautiful Resurrection Bay and her territory extends for several hundred miles south and west among the islands and along the coast of the Peninsula.

On these islands, which are inhabited largely by Indians and half-breeds who trap furs for a meager living, health facilities are entirely lacking, there being no hospital and only an occasional visit from a missionary doctor. Two little steamers and small schooners ply between the islands which will be Miss Fuller's means of transportation about her district.

At Seward itself, an up-to-date prosperous northern "city" with a population of 500, mostly Americans, there is an active and flourishing chapter of the American Red Cross with branches at Kodiak Island, Seldovia, Unalaska, Nushagak and Afognak. Seldom will a nurse receive a warmer welcome than will Miss Fuller from the Red Cross people of Seward who expressed the greatest delight and appreciation on receiving the news that they were to have a Delano Red Cross Nursing Service. Their enthusiasm is contagious and two other Alaskan chapters are making plans for a public health nursing service.

The Seward Chapter already has an active program of home service work, volunteer service and Junior Red Cross activities. The Juniors have been especially active the past year in getting the material needed in fitting up the school gymnasium, installing a moving picture machine and making over the basement for play purposes. Miss Fuller will find her work greatly facilitated by a large group of eager helpers. She is particularly well fitted for the pioneer work which she will be called upon to do, having had a sound fundamental hospital training, with several years of private duty nursing, some time in school teaching and a wide experience in the different aspects of public health work, district nursing, infant welfare, school nursing, tuberculosis work, hospital social service and public speaking on the Chatauqua circuit. Her foreign service with the Red Cross overseas was equally varied, including work in the Tuberculosis Bureau, military hospitals, *Service de Sante* and the Childrens' Bureau.

The second Delano Red Cross nursing service is on the bleak islands of Penobscot Bay off the Maine coast inhabited by fisher folk of good American stock, but who on account of the rigorous winters are cut off from communication with the main land for several months out of the year. There is no hospital on the islands and no resident physician.

There is a great need here for the teaching of Home Hygiene and Care of the Sick and for the work of a Public Health Nurse, and Edith Spiers, an experienced Public Health Nurse, will undertake both. A graduate of the Arlington, Massachusetts Hospital, she has had several years experience in district nursing and has served as Public Health Nurse to three Red Cross chapters in Texas and in Massachusetts. In the Penobscot Bay service, she takes the place of Bertha Steeves, who had been assigned to this position but who

for reasons of ill health was unable to undertake it.

THE PROGRESS OF RED CROSS PUBLIC HEALTH NURSING IN PORTO RICO

In May 1921, Kathleen d'Olier, who had organized infant welfare so efficiently in Athens, Greece, undertook the work of organizing and developing public health nursing under the Red Cross chapter in Porto Rico. Her program has been largely infant, maternal and child welfare work, but has grown to include school and tuberculosis nursing. The following excerpts from her annual report show the amazing rapidity with which this service has grown and its effectiveness is reflected in the marked reduction in the infant death rate:

"At the time of the annual meeting a year ago, the nursing service had opened a small office in Puerta de Tierra, had employed a superintendent and two staff nurses and had been running two clinics a week for one month. Today, it is running seven clinics weekly in six different sections of the Island, and has a staff of ten nurses. This remarkable progress has been made possible by the devoted work of the executive committee and subcommittees in various sections. The loyal service of the nurses and the attending physicians as well as the hearty co-operation of such other agencies as the Insular Health Department, the municipalities of San Juan, Ponce, Bayamon and Manati, the hospitals and Bureau of Tropical Medicines, the Junior Red Cross, the Department of Education, the Anti-Tuberculosis League and many individual volunteer workers.

"The clinics in Puerta de Tierra are the only ones that have been in operation a whole year. During the year, six hundred and sixty-three new babies have been treated and two hundred and fifty-four expectant mothers cared for and instructed by the doctors and nurses in hygiene and infant care. While our work in this district has been generally confined to the care of mothers and babies, we have found it impossible to refuse care to other cases, especially school children. The children from all of the schools in the district have come to us for treatment of defects, and through the kind co-operation of the various specialists in San Juan, many have been fitted with glasses or received surgical care. The nurses have also spent many hours at the *Hogar Infantil* in assisting with cases of illness developing in children there. The work in the district has been handicapped by lack of space for teaching and clinic work. This will be remedied during the coming year. Another handicap has been the frightful housing situation due to the dredging of the harbor. This condition is growing constantly worse and little can be done to save infant life in homes standing many feet in stagnant water and sewerage.

"However, the figures given by the Sanitation Department, just after this year of nursing service for the Barrio of Puerta de Tierra, are very encouraging and speak for themselves of the value of the work.

JUNE, 1920—JUNE, 1921

Number of deaths among babies	144
Number of deaths among children under 2 years of age	49

JUNE, 1921—JUNE, 1922

Number of death among babies	84
Number of deaths among children under 2 years	14

(This is the year the clinic has been in operation).

"The last station opened is the one in La Perla. In this district practically every infant has come under the care of the doctor and nurse. Every child in the school has also been examined by the city physician and the nurse has had unusual success in having the defects found remedied. The nurses in their districts have made 20,097 home visits.

"In every district where we have worked, we have found patients suffering from tuberculosis. There are no clinics especially for the diagnosis or treatment of this disease and only about one hundred and twenty-five hospital beds available on the Island. We have often found as many as ten individuals living in a single room with an active case of tuberculosis.

"An appeal was made in March to the Anti-Tuberculosis League and since that time they have furnished us with one nurse to investigate and instruct the cases found in Puerta de Tierra.

"For the past six months the Chapter has been interested in a plan to gain the co-operation of the U. S. Public Health Service in dealing with the tuberculosis situation. An appeal has been made through the Governor to Surgeon General Cummings, with the result that within a month Dr. F. C. Smith of the tuberculosis section, Hospital Division, U. S. P. H. S., will come to Porto Rico to make a brief survey of conditions and decide whether the Public Health Service should send a staff of workers to the Island.

"The Department of Sanitation has been most generous in co-operating with us in the past and has promised added co-operation during the coming year, so that the opening of at least two other clinics is assured. We also hope for the same generous co-operation from the Junior Red Cross that we have had during the past year.

KATHLEEN D'OLIER
Supervising Nurse."

NEWS FROM THE FIELD

TWO IMPORTANT MEETINGS

The Annual Meeting of the American Child Hygiene Association will be held in Washington, D. C., October 12-14, 1922.

The Annual Meeting of the American Public Health Association is to be held in Cleveland, Ohio, October 16 to 19, 1922.

Joint meetings of the Industrial Section (Dr. Wade Wright, Chairman) and the Ohio Association of Industrial Physicians (Dr. Sydney S. McCurdy, President) will be held October 17th and 18th, and it is felt that these meetings should be of particular interest to industrial nurses. The program will include discussion of the following subjects:

The Tuberculosis Problem in Industry; Industrial Dermatoses; Health Education in Industry; Causes of Absenteeism among Store Workers; Computation of Partial Loss of Vision; Mental Hygiene in Industry; Heat Hazards in Industry.

MEETING OF AMERICAN DIETETIC ASSOCIATION

The American Dietetic Association will hold its Fifth Annual Meeting in Washington, D. C., October 16-18, with headquarters at the New Willard Hotel.

Speakers of national importance will discuss recent developments in dietetics, as well as administrative and other practical problems of the dietitian. Also, trips to Walter Reed Hospital and the scientific laboratories of the Government will give excellent opportunities to observe the research work now carried on in Washington.

An exhibit of equipment, food materials, charts and other illustrative matter valuable to the dietitian will also be an attractive feature of the Convention.

A PLAN OF NEW YORK*

The Trustees of the Russell Sage Foundation have appointed a Committee to consider the problems created by the concentration of population in and about the City of New York. A meeting was called on May 10th at which announcement was made that a comprehensive regional plan of New York and its vicinity is being developed by the Foundation. Robert W. De Forest presided, and short addresses were made by Charles D. Norton, Herbert Hoover, Lillian D. Wald, John J. Carty, Elihu Root and Mrs. August Belmont. In announcing the project, Charles D. Norton quoted from the report of the Commission of 1811, by whom the present street plan of Manhattan Island was drawn up at a time when New York had a population of less than 90,000:

"It may be a subject of merriment that the commissioners have provided space for a greater population than is collected at any spot on this side of China * * * It is not improbable that considerable numbers may be collected at Haerlem before the high hills to the southward of it shall be built upon as a city, and it is improbable that (for centuries to come) the grounds north of Haerlem flat will be covered with houses * *

"It may be a matter of surprise that so few vacant spaces have been left and those so small; for the benefit of fresh air and consequent preservation of health. Certainly if the City of New York were destined to stand on the side of a small stream such as the Seine or the Thames, a great number of ample places might be needful; but those large arms of the sea which embrace Manhattan Island render its situation, in regard to health and pleasure, as well as to convenience of commerce, peculiarly felicitous; when therefore, from the same causes, the price of land is so uncommonly great, it seemed proper to admit the principles of economy to greater influence than might, under circumstances of a different kind, have consisted with the dictates of prudence and the sense of duty."

"These 'principles of economy,'" said Mr. Norton, "applied to Manhattan Island in 1811 have yielded their logical and disastrous harvest of congestion and confusion in 1922. Embraced by 'those large arms of the sea,' rigidly bound to a street

* Plan of New York and Its Environs. The Meeting of May 10, 1922.

scheme designed in 1811, Manhattan has leaped into the air; it has tunneled and bridged the rivers; it has thrust out its transportation arms until men and women travel fifty miles to their daily labor in the city; until the great area of which Manhattan is the center is in 1922 the home of no less than nine millions of people.

Miss Wald spoke in part as follows:

"This seems to me a most important first step towards the most important undertaking that I have heard of for many years. I believe that if it is carried out in logical sequence it will add greatly to the happiness of the people of New York. It links a practical, workable plan with the vision of a city conceived in understanding of the needs of many people, their homes and those matters most closely related to their daily life.

It rouses within me a hope that those who come after may profit by this responsibility for them and our remorse for past omissions. I am enthusiastic because I see the possibility of realizing a hope that lies deep in the hearts of all lovers of mankind, and particularly the lovers of little children—that it is possible to have a city beautiful, and that ugliness is entirely unnecessary. When the stranger comes to America, often with great ideals, he meets first the ugly, commercialized, unsocial—often anti-social—section of the city into which he moves. I fully understand that even a perfectly planned metropolitan area will not bring about the millenium; but organized, co-operative plans that bring people together, that comprehend the interrelationship of home and work, recreation and education, will make impossible the further growth of segregated, ugly quarters for racial groups or economic classes.

There is bound to develop among those entrusted with the plans, and the public through them, the conviction that no city is really dignified unless there is within it a consciousness that children can be brought up safely only if the homes are fit for children to be brought up in * * *.

As I sense the aspirations of anxious parents, I can say with them that we long for decent homes, for wholesome recreation, for proximity to employment, and for transportation facilities that do not make the coming and going from work to home a most unpleasant experience. We also aspire to schools and playgrounds placed with a conception of the distance that children can safely travel. And we hope for prohibition of the ugly commercialized houses which are only too flatteringly called "homes." A great plan that has the advantage of the counsel of experts in every field—not working as specialists but working together for the city made up of homes—will establish standards, and the necessary provisions and prohibitions will naturally follow.

Imagination soars to the ultimate possibilities of not only a physically planned city, but development of other measures that are akin to it. I see, for instance that a great city plan could be made available for giving employment for public works during periods of industrial idleness.

I see also in the plan, lastly but by no means of least consequence, recognition of the need of beauty; a need that exists, whether consciously or unconsciously, in the souls of people, even the least. Looking up Henry Street, the Woolworth Building can be seen in the distance. One of our children not long since, gazing westward, saw the beautiful building in the sunset light and, all unconsciously comparing the shining vision with the ugly, overcrowded, unclean, garbage-decorated houses about her, and obviously awed by the sight, exclaimed "Does God live there?"

We have beauty in the city—perhaps more than we deserve, because so much of it has either been accidental or due to the conception of an individual; but on the whole, beauty has not touched our homes, our industrial streets or our factories; not, I believe, through any prejudice against beauty, even for these functions and purposes of the city, but because the city, like Topsy, grew up, and a planless city inevitably becomes a city of specialization, not a co-ordinated social structure."

BUSINESS PRINCIPLES APPLIED TO WELFARE AGENCIES

The application of modern business principles to welfare agencies, and the increased returns on the funds contributed effected thereby, are described in a report just made public by the U. S. Department of Labor through the Children's Bureau. This report, entitled "Office Administration for Organizations Supervising the Health of Mothers, Infants, and Children of Pre-school Age," is the outgrowth of requests for advice which came to the Children's Bureau from organizations in various cities. It embodies the experience of members of the staff whose services were loaned for studies and consultations, and the results of a study of methods used by 200 nursing agencies in both large and small communities. Although the report is directed especially toward the needs of agencies supervising the health of mothers and young children, certain fundamental principles set forth are applicable to

the conduct of any office in the social field.

The report is not intended for the larger organizations alone. It is not unreasonable to suppose, it states, that the waste occurring in the small public health nursing organizations throughout the nation bulks greater than the total waste of the large organizations. The office may be the desk of the one nurse who is executive and staff at one and the same time, but the application of the fundamental principles of management are nevertheless necessary to efficient service.

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COMBINED NATIONAL EXHIBIT

A National Committee on Exhibits Showing Advances in Sanitary Science has recently been formed in Washington, D. C., for the purpose of collecting and preparing material for a great popular health exhibit in the Capitol. The members of the committee include:

Surgeon-General H. S. Cumming, U. S. Public Health Service, Chairman.
Dr. D. B. Armstrong, National Health Council.
Miss Mabel T. Boardman, American Red Cross.
Surgeon-General M. W. Ireland, U. S. Army Medical Corps.
Dr. Victor C. Vaughan, National Research Council.
Dr. C. D. Wolcott, Smithsonian Institution.
James A. Tobey, National Health Council, Secretary.

Space for the proposed exhibit has been placed at the disposal of the Committee by the Smithsonian Institution, which is visited by more than half a million persons annually. Plans are under way to install exhibit material secured from official and voluntary health agencies.

U. S. CIVIL SERVICE EXAMINATIONS

Graduate Nurse
Graduate Nurse (*Follow-Up*)

To fill vacancies in the U. S. Veterans Bureau, Indian Service, Public Health Service. Applications received up to December 30, 1922.

Trained Nurse
Trained Nurse (*Psychiatric*)

For Panama Canal Service. Open competitive examinations to be held October 18, 1922.

For further information apply to the U. S. Civil Service Commission, Washington, D. C.

GOOD HEALTH WEEK

The Good Health Week Promotion Bureau announces October 23-29 as Good Health Week. An outline of the activities to be undertaken during that week has been drawn up under the title "Telling the Nation." Copies of this pamphlet may be obtained from the Bureau, Room 704, 209 Grand Avenue, Milwaukee, Wis.

THE INTERNATIONAL COUNCIL OF NURSES

The Grand Council of the International Council of Nurses was held at Copenhagen from May 22 to 24, 1922, inclusive, upon the invitation of the Danish Council of Nurses. The meeting was of an official rather than a general nature and delegates from the ten following countries were present: Denmark, Great Britain and Ireland, United States of America, India, South Africa, Holland, Fin-

land, Belgium, Italy and Norway. Baroness Mannerheim, President of the Association of Nurses of Finland, accepted the office of President for the next triennial period, to which she was elected.

Invitations for the holding of the next Council Meeting were extended by the United States and Finland. As the expenses of a journey to America were prohibitive for most European nurses, it was decided to accept the invitation from Finland and to hold the congress at Helsingfors in 1925.

Among the topics discussed were:

1. What could be done to facilitate the reception of trained nurses in the hospitals of the different countries.
2. The necessity for an international standard of nursing education.

The following resolutions were passed:

RESOLUTION 1

We resolve that our recognized standard for trained professional women nurses be: Certification after a minimum of three years' continuous training in recognized qualified Training Schools.

Recommended:

(a) That the Training School shall be under the direction of a trained professional Nurse Superintendent.

(b) That she shall arrange and maintain the Standard Curriculum to be given under the direction of a professional nurse, especially qualified for the purpose.

RESOLUTION 2

We resolve that the obtaining of State Registration and Recognition be urged upon those National Councils in the countries where it is not already in force, in accordance with the standard laid down in Resolution 1.

NEW DIRECTOR OF DIVISION OF VENEREAL DISEASES

Assistant Surgeon General Mark J. White has succeeded Dr. C. C. Pierce as Director of the Division of Venereal Diseases. Dr. White has had a long and wide experience as a Public Health Officer and comes to the Division not only with a thorough knowledge of the venereal disease problem but with a keen appreciation of the value of nurses and the part they have to play in this campaign. To quote Dr. White: "I feel that after the diagnosis is made, and indeed in many instances before it is made, the nurse with her training in social medicine, her aptitude in gaining the confidence of patients, with her knowledge of the importance of waging unrelenting warfare against disease, makes her a most important factor in the treatment, control and cure of venereal disease."

The public health nurses of the country may feel that in Dr. White they have a most worthy ally in their campaign for better health.

AN IMPORTANT CONFERENCE

The first meeting of the European Council for Nursing Education was held at Prague, May 30th to June 1, 1922. The Conference was called by the American Red Cross. The nurse directors of training schools and others interested in nursing education in Europe were invited.

At the conclusion of the conference all present agreed that so much had been gained by the opportunity for each representative to hear the problems and achievements of her colleagues and to discuss her own, that it was decided to form a League known as the "European Council for Nursing Education" of which Miss Marian Parsons, Prague, was elected Chairman, with the privilege of selecting a secretary-treasurer. A committee was elected to draw up the necessary by-laws and statutes for the Council. Meetings will probably be held at least once yearly. The formation of this council will undoubtedly promote unified action by the different countries in the stimulation of higher and better nursing education.

NOTES FROM THE STATES

Colorado

Dr. William R. P. Emerson of Boston, national authority on the malnourished child and organizer of the nutrition class method, is to give a Nutritional Institute in Denver, October 18th to November 1st, under

the auspices of the Colorado Tuberculosis Association, 409 Barth Building, Denver, Colorado. This Institute, although open to physicians, teachers and social workers, is of paramount value to public health nurses. It covers all phases of nutrition work: identification of the malnourished child, physical, mental and social history records, statistics, class procedure, medical agencies and how to use them, social agencies and how they can help, school lunches, the disorganized home, health habits, food habits, overfatigue and practical psychology. For demonstration purposes, nutrition classes in the Denver schools and the Open Air School will be available. There will be half day sessions daily. The cost of tuition will be $25.00, $5.00 payable upon application, the balance to be paid at the time of registration. Checks should be made payable to the Colorado Tuberculosis Association. The Y. W. C. A., will offer its services in finding living arrangements for students outside of Denver.

Kansas

At the Annual Meeting of the Kansas State Board of Health, held June 29 and 30, Dr. S. J. Crumbine, Chief Executive Officer, recommended to the Board that action be taken creating a Division of Public Health Nursing in the State Board of Health; this division to function as all other divisions. The Board unanimously voted to create such a division, the director of which should be responsible only to the Chief Executive Officer. We understand that it is the intention of the Board to ask the next Legislature to establish the Division by law.

There is now a staff of four nurses under the State Board of Health, a Director (Miss Hulda A. Cron, R. N.,) and three field advisory nurses. The Division of Public Health Nursing will assume full responsibility for all nursing work done by any Division in the State Board of Health. Because of the great distances in Kansas, the field advisory nurses will have their headquarters in three different cities—Topeka, Salina, and Wichita.

The Division of Public Health Nursing in the Kansas State Board of Health has, with the co-operation of the State Traveling Libraries Commission, established a circulating public health nursing library service for the public health nurses employed in the state. This library is indebted to the National Organization for Public Health Nursing for the collection of pamphlets and reprints.

Kansas public health nurses wishing to make use of this library should address the State Board of Health, Topeka, Kans.

Massachusetts

The Baby Hygiene Association of Boston has just issued its Thirteenth Annual Report, covering the year 1921. The statistics given show a new low mortality rate for the Association—a rate of 12.54 per 1000 deaths, for the 9722 infants registered; as compared with a rate of 77.8 per thousand for the city as a whole. While it is pointed out that the comparison with the city rate cannot be exact, since few babies come to the Association newly born, when the average mortality is highest; yet, on the other hand, the babies under the care of the Association comprise about one-third of all the babies of the city, and their low mortality rate exerts an important lowering effect on the rate for the city at large.

Lack of funds has made it impossible to give to babies over one year old the attention they so evidently need, and this fact is mirrored in the increased mortality rate of the children between one and two years —14.3 per 1000, as against the 12.54 rate for those under one year.

Late in the year there was opened in connection with the South End House, a clinic on Health Habits, one of the first constructive efforts in practical mental hygiene. This clinic is conducted by Dr. Thom, of the Psychopathic Hospital.

NOTES FROM THE STATES
(*Continued*)

Missouri

The St. Louis Association for Social Work has attached a notice to the Eleventh Annual Report, calling attention to a change of name, the Association now being known as St. Louis Hospital Social Service. The Report covers social service work in Barnes Hospital, St. Louis Children's Hospital, Washington University Dispensary and Jewish Hospital. Besides the reports of the President and the Director of the staff, there are very interesting sections by workers in the following departments: General Medical, Cardiac, Chest, General Surgical, General Children, Prenatal, Infant Welfare, Orthopedic, Venereal Clinic, Luetic Children, Nerve Clinic, Nose and Throat Clinic, Jewish Hospital, Junior League Workshop, Barnes Hospital Occupational Therapy Department; and even "The Automobile," which, by doubling the amount of work that can be accomplished, has itself rightfully attained to the dignity of a "social worker," has a brief section of its own and holds the centre of the stage in the excellent illustration of crippled children being brought to the hospital, which is published on the last page of the Report.

"Why not live your three score years and ten?" is the pertinent question asked by the St. Louis County Public Health Association on the cover of the Annual Report published June 1922. The Association conducts free clinics throughout the entire county and helps to prevent disease by such educational methods as health exhibits, lectures, Modern Health Crusade, etc. The Report is enlivened by several poems appropriate to health and welfare work.

Ohio

The Federation of Women's Clubs have agreed to equip the second prenatal clinic in Akron. This clinic will be opened at Community House Health Service Station. The action

NOTES FROM THE STATES

(Continued)

of these club women is significant, as showing the interest taken in public health nursing by the women of Akron.

Oregon

"Public Health Nursing in Oregon" is the title of an attractive pamphlet recently published by the Oregon Tuberculosis Association and the Bureau of Public Health Nursing and Child Hygiene of the Oregon State Board of Health. It sets forth briefly, first, "What is a Public Health Nurse," then gives short, descriptive explanations of what constitutes Child Welfare Nursing; Prenatal Nursing; School Nursing; Tuberculosis Nursing; Industrial Nursing; Mental Hygiene. The latter half of the pamphlet is devoted to the subject of County Public Health Associations, and finally, the work and relationship of the county nurse to her own association and to certain official organizations. The whole forms a simple, useful handbook.

Those of us who had the privilege of attending the Seattle Convention were no doubt struck by the fact that the whole staff of the Portland Visiting Nurse Association were present. Some of us can appreciate what a great amount of planning this meant, and we feel that it is symbolic of the general attitude of the Association, and the ambition of the Superintendent and each member of the staff to seize upon every opportunity to improve their equipment for their work.

The Twentieth Annual Report of this Association reflects the same desire for self-improvement—an anxiety to join forces with all groups engaged in the cause of *prevention*—and an outlook eager to provide those services still lacking to a complete program of work, such as a psychiatric clinic, a mental hygiene division and an industrial division.

We like the illustrations—especially the one which shows Mt. Hood in the background.

ECONOMIC ASPECT OF POOR VISION

Recent studies show some startling results as to the prevalence of defective eyesight.

In the examination of more than 10,000 employes in factories and commercial houses, 53 per cent were found with uncorrected faulty vision, 13 per cent had defects which were corrected, making a total of 66 per cent with defective eyes.

In one manufacturing establishment over 70 per cent were found with eye defects.

In another plant the following startling condition was discovered:

Glasses worn and satisfactory	8+%
Glasses needed and ordered	83+%
No glasses needed	8+%

As an example of inefficiency and resulting waste, 20 per cent of the inspectors in a large factory were found to be unable to see *sufficiently well* to detect defects in the product they were inspecting.